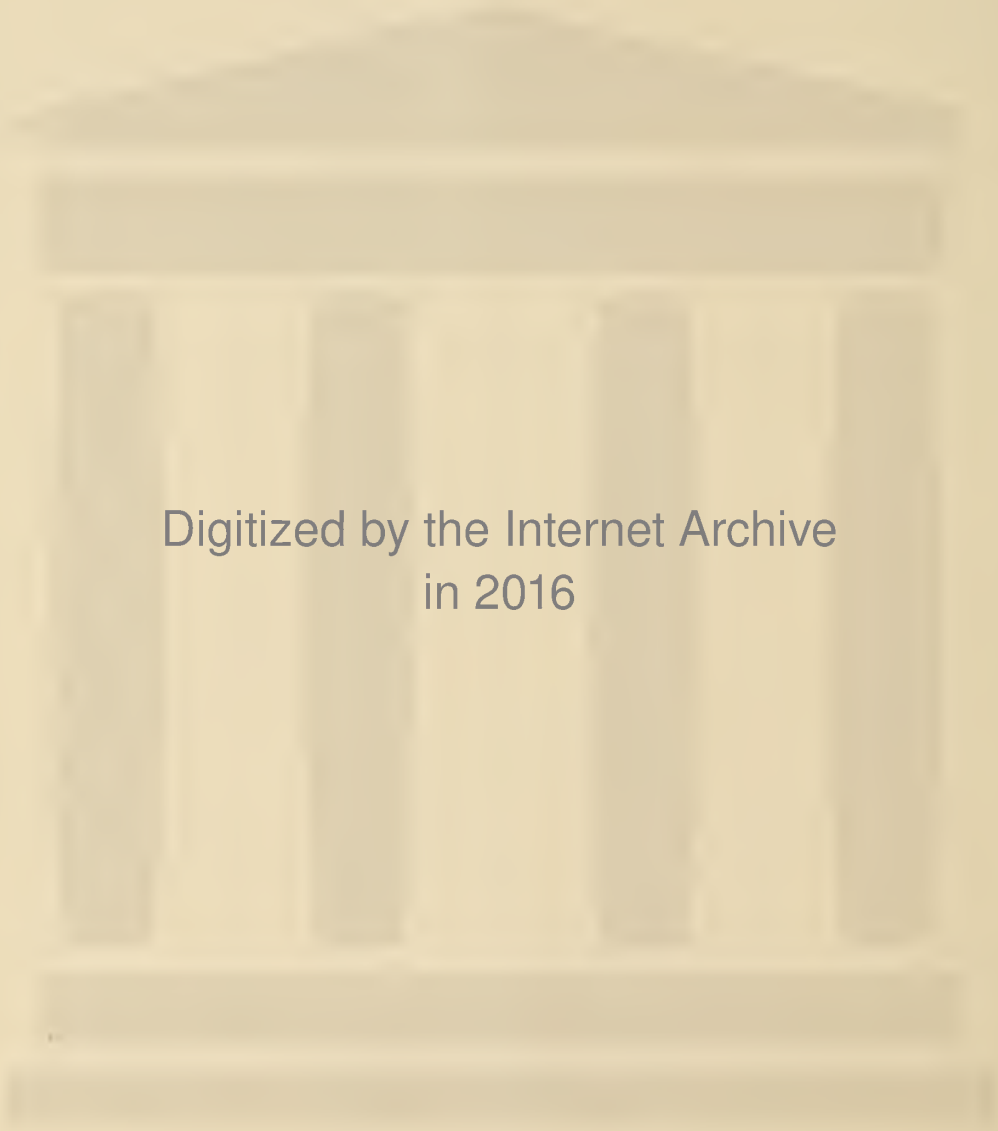
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Or.—Original Article.
C. R.—Case Report.
B. M.—Bedside Medicine.
Ed.—Editorial.
E. C.—Editorial Comment.
C. N.—Clinical Notes.
L. M. H.—Lure of Medical History.
Sup.—Supplement (by month).

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Meeting, *Second Sunday.*

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President, Ream S. Leachman, 727 Sonoma St., Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

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President, Alfred A. Thurlow, 505 B St., Santa Rosa.
Secretary, C. M. Carlson, 534 B Street, Santa Rosa.
Meeting, *Second Thursday.*

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President, Marion C. Collins, Turlock.
Secretary, Edwin F. Hagedorn, Box 834, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, J. C. McClure, Lindsay.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, F. R. Hendricks, 885 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Stanley E. Coffey, 239 Fourth Street, Orland.
Secretary, Ray E. Nichols, Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society
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(Roster lists continued on advertising page 6)

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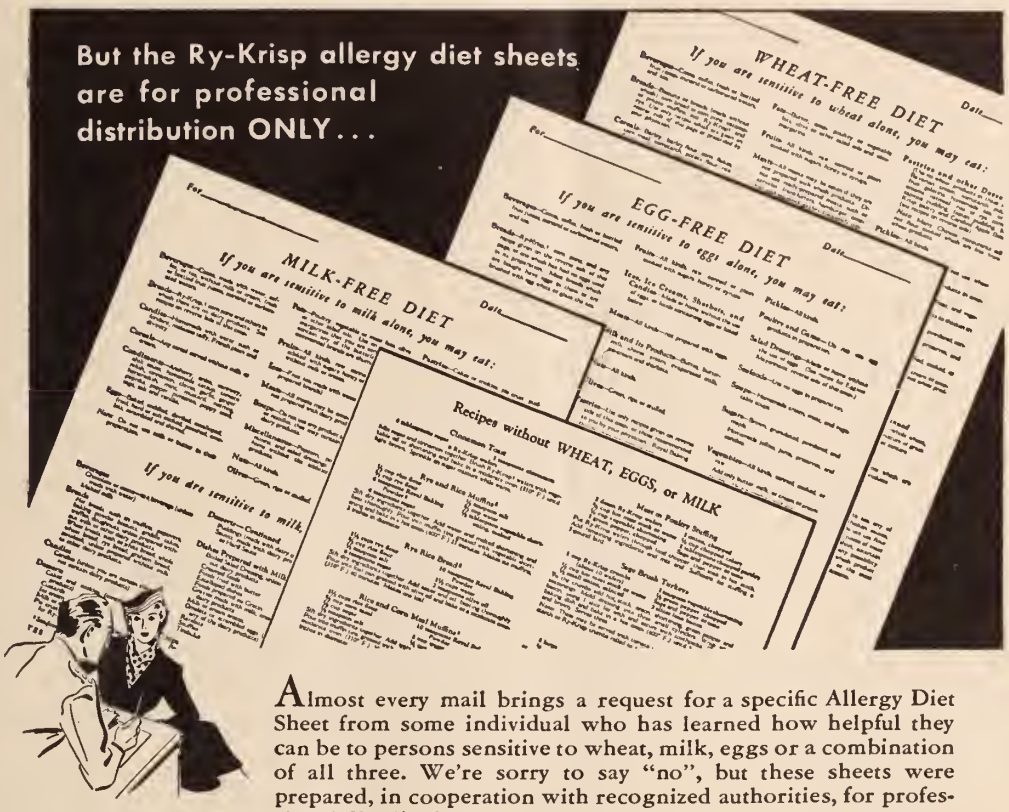
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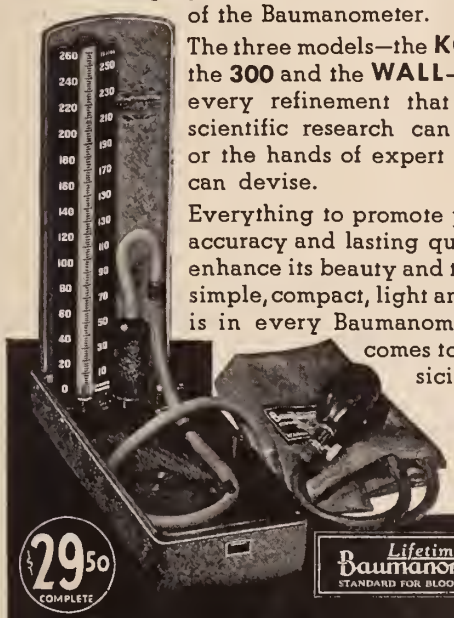
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Danger to Children of Lead in Colored Chalks.—Jephcott analyzed the colored chalks of five manufacturers. It was noticed that chalks of certain colors, yellow, orange, and green, contained in some cases relative large amounts of lead chromate. No lead was present in white, red, blue, brown, and black chalk. Cleaning blackboards and brushes in school, often performed by children, will be accompanied by the inhalation of lead dust when such chalks are used. It is likely that crayons should be viewed with the same suspicion. When it is realized that not more than 0.6 gram of metallic lead has caused a fatal case of lead poisoning, it is evident that these chalks, if continuously nibbled by children, contain sufficient lead to cause plumbism.—*Canadian Public Health Journal.*

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

The Negro's Struggle for Survival: A Study In Human Ecology. By S. J. Holmes, Professor of Zoölogy in the University of California. Cloth. Pp. 296. Price, $3. Berkeley: University of California Press, 1937.

International Clinics. A Quarterly of illustrated clinical lectures especially prepared original article on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest. By leading members of the medical profession throughout the world. Edited by Louis Hamman, M.D., Visiting Physician, Johns Hopkins Hospital, Baltimore, Maryland. Volume IV, Forty-Seventh Series, 1937. Cloth. Pp. 343. Philadelphia: J. B. Lippincott Company, 1937.

Practical Proctology. By Louis A. Buie, A.B., M.D., F.A.C.S., Head of Section on Proctology, The Mayo Clinic; Professor of Proctology, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Cloth. Pp. 512, with 152 illustrations. Price, $6.50 net. Philadelphia: W. B. Saunders Company, 1937.

A Primer for Diabetic Patients. By Russell M. Wilder, M.D., Ph.D., F.A.C.P., Professor and Chief of the Department of Medicine of The Mayo Foundation, University of Minnesota; Head of Section on General Metabolism, Division of Medicine, The Mayo Clinic. Sixth Edition, Reset. Cloth. Pp. 191. Price, $1.75 net. Philadelphia: W. B. Saunders Company, 1937.

A Handbook of Accepted Remedies. Symptoms and Treatment of Poisoning. Diagnostic Procedures. Miscellaneous information. Edited by P. J. Hanzlik, M.D., Professor of Pharmacology, Stanford University School of Medicine, San Francisco. Second Edition. Paper. Pp. 115. Price, $1. Department of Public Health, San Francisco, J. C. Geiger, Director. San Francisco: J. W. Stacey, Inc., 1937.

Mentality and Homosexuality. By Samuel Kahn, B.S., M.A., Ph.D., M.D., Formerly on the Psychiatric Staffs of Kings County and Kings Park State Hospitals, New York; New York County Penitentiary, and Sing Sing State Prison, New York; Associate Attending Neurologist at the City Hospital and Central Neurological Hospital, New York. Cloth. Pp. 249. Price, $3. Boston: Meador Publishing Company, 1937.

(Continued on Page 15)

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*J. A. M. A., July 31, 1937. P. 330.
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BOOKS RECEIVED

(Continued from Page 13)

Surgical Anatomy of the Head and Neck. By John Finch Barnhill, M.D., F.A.C.S., LL.D., Formerly Professor Otolaryngology in the Indiana University School of Medicine. Emeritus Professor of Surgery of the Head and Neck. Formerly Chief of the Department of Head and Neck Surgery in the Indiana University Hospitals. Honorary Professor of Anatomy, University of Southern California School of Medicine. Introduction by Paul A. McKibben, Professor of Anatomy in the School of Medicine, University of Southern California. Cloth. Pp. 921. Price, $20. Baltimore: William Wood & Company, 1937.

Lane Medical Lectures: The Mechanism of Heat Loss and Temperature Regulation. By Eugene F. Du Bois, Medical Director, Russell Sage Institute of Pathology, Professor of Medicine, Cornell University Medical College, Physician-in-Chief, New York Hospital, New York City. Medical Sciences, Volume III, Number 4. Paper, $1.50. Cloth, $2.25. Pp. 92, illustrated. Stanford University: Stanford University Press, 1937.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 72)

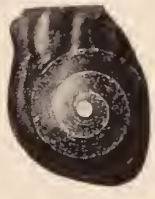
it in the eastern journals, to have been a marked success. The program was certainly enormous enough to satisfy the most greedy, and to furnish anyone, with surgical yearnings, enough material for long and careful thought. It has been suggested that the surgical congress be invited to meet in San Francisco in 1915, but when one considers the program offered at the last meeting, and the paucity of clinics and clinical material to be demonstrated in San Francisco, it would almost seem to be an excess of temerity even to suggest such a thing, no matter how greatly we might desire to be the hosts of the surgical congress. Just what congresses or conventions will be held in San Francisco in the exposition year, it is not possible to say. The American Medical Association will be invited to meet

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

there, and a committee of the Association has suggested that a large congress of those interested in hygiene, preventive medicine, tropical diseases, etc., be held in connection with the exposition. What will be the outcome of this proposition remains to be seen; of course the Association cannot decide until 1914 the place of meeting in 1915, but at the present writing there seems to be a certain feeling of willingness to come to San Francisco at that time.

* * *

Bohanon Amendment Unconstitutional.—The legislature, two years ago, passed an amendment to the California medical law which was signed by the governor on the last day of statutory grace. This amendment compelled the board to issue a license to anyone practicing a specialty, provided he had practiced it for thirty-five years and in California for fifteen years. In other words, it licensed anyone who had broken the laws of the State for fifteen years to keep on with the work that was originally illegal! Bohanon, a cancer "specialist" of Oakland, applied, with several others, for a license under this amendment. The Board of Examiners denied the application and he took the case into court where the law was decided to be unconstitutional. He will, in all probability, take the case to a higher court unless the present legislature passes another amendment designed to fit his particular case.

* * *

Widely Distributed Interest.—It has been a matter not only of great interest, but of some small pleasure to note the widely distributed territory in which the *Journal* seems to be of enough interest to be fairly well read—or looked through. A few copies go into nearly every state in the United States, and some to England and Europe generally. At least one reader in every state in which the *Journal* circulates, has written to us asking for the "collection stickers" (devised by Secretary Kress of the Los Angeles County Medical Association), to which attention was called in the September issue; two or three requests have come from England and Canada, and the following postcard was recently received from a reader in Germany: "You would much oblige us by sending us a set of 'stickers' as mentioned in the *State Journal.*" Even our advertising pages seem to be worth the attention of a good many who receive the *Journal*; they are readers who are up-to-date; no one can be up-to-date, in these days, unless he pays attention to the advertising pages of the reputable publications that pass through his hands.

From an article on "The Milk Supply of San Francisco and Its Bacterial Content." By E. E. Hutshing, Ph.C., San Francisco, Bacteriologist with San Francisco Board of Health.—Of the various classes of milk, shippers, wagon, creamery, depot, etc., of which samples are taken by the Health Department's inspectors to be submitted to its laboratories for examination, only the first-named is regularly put through the routine bacteriological examination. By shipper's milk is meant that which comes direct from the source of supply, namely, the dairy.

From an article on "Postoperative Acidosis," by Charles G. Levison, M.D., San Francisco.—In former years, when chloroform was in general use as an anesthetic, conditions at that time called uremia, secondary shock and latent sepsis were frequently observed. With the introduction of ether, however, these conditions have been less frequently seen. The untoward effects of all anesthetics during the past ten years have been steadily growing less as a result of the following factors:

1. The large reduction in the quantity of the anesthetic consumed on account of the drop-method, plus nitrous oxid, morphin, scopalamin and novocain.

(Continued on Page 19)

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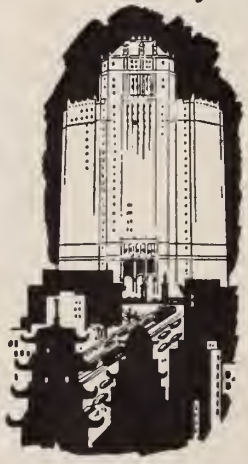
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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

2. Shorter duration of operation.
3. A shorter period of preliminary starvation and purgation.

From an article on "Epidemic Poliomyelitis," by Philip King Brown, M.D., San Francisco—Historically, there was no special importance attached to this disease until its significance as a contagious epidemic disorder was emphasized in recent years. That it has existed endemically, but infrequently, in all parts of our land was apparent, but that it should become an almost national problem was due solely to the appreciation of its epidemic character. In this rôle it comes close home to us, and especially to you residents of this valley, since the first epidemic of the disease in this State, and the third recorded in America, occurred in June, 1898, at La Grande, not more than twenty miles distant. To Newmark's service in the San Francisco Polyclinic, two of the affected children were brought, and from the history obtained it seemed that other similar cases had occurred.

From an article on "The Diagnosis of Tuberculosis of the Skin," by D. Friedlander, M.D., San Francisco.—In the diagnosis of tuberculosis of the skin, we are confronted with a difficulty that we do not have to contend with in the gross pathological conditions of the same process in other organs of the body, inasmuch as we have, in tuberculosis of the skin, a variety of lesions which differ widely clinically, depending on the duration, intensity and evolution of the process, as well as the results of treatment. Not only in the clinical appearance does this wide variation occur, but also in the histological picture do we find the greatest latitude.

From an article on "Transfusion," by N. H. Chamberlain, M.D., Oakland.—Although, in the broader sense, transfusion includes the introduction of any fluid into the body, even saline solutions, we will use the word only to mean the causing of flow of blood directly from the vessels of one human being into the blood vessels of another.

From some News Notes from Newspapers:

Dr. Henry S. Orme, one of the oldest members of the State Society, died in Los Angeles on November 30, 1912. An obituary notice will appear in a later issue.

The State Commission on Tuberculosis (its chairman, Dr. George H. Kress, presiding), held a meeting in San Francisco on the 14th of December, preparatory to making its report to the next legislature.

"Dr. Albert Abrams of San Francisco," says the *Examiner*, "has succeeded in procuring the convention of the American Association of Spondylotherapy for 1915." Fine! That means that Doctor Abrams has procured himself for 1915.

Dr. E. O. Sawyer, county health officer of Los Angeles County, was given a banquet—and a gold badge—by many physicians and friends, on November 22. Los Angeles is certainly to be commended for its high development of the banquet idea.

Dr. O. D. Hamlin, who acquired a game knee while East last summer, has invented a new way of shooting ducks. He sits on a piano stool, in a blind, and thus orientates himself to correspond with the migratory duck with the least amount of effort and personal disturbance.

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Mr. Hubert T. Morrow, our attorney for Southern California, has been delivering a number of public lectures on the "Fight Against Criminal Practices." It is to be hoped that he can arouse some little interest on the part of the laity, for unless the layman wants these laws enforced, they will be dead letters.

Los Angeles has many very fine characteristics, not the least of which is its firm belief in the beneficial effect of banquets. On December 13, some eighty physicians of that community tendered a banquet to Dr. E. R. Smith upon the occasion of his retiring from active practice. Dr. H. Bert Ellis was the chairman, and Dr. Norman Bridge the toastmaster.

The Fresno *Mirror,* referring to abortionists and their use of the advertising pages of newspapers, makes this ingenuous remark: "We suggest that the next legislature pass a law making it a felony for newspapers in this State to publish the advertisements of such doctors and drug concerns." Bless you, dear *Mirror,* don't you know that such bills have been presented in nearly every legislature for twenty years, and have been defeated—by the newspapers? They want the dirty money.

Red Water Masses Caused by Mussel Poison Organism.—The appearance of spectacular patches of red water in the ocean off Central California, coupled with a simultaneous incidence of twenty-one cases of the dread mussel poisoning, has occasioned a sharp acceleration of the campaign being conducted by the State health authorities and the University of California Medical School against the spread of such poison cases. The discoloration of the water was created by the presence of masses of the goniaulux microörganism, which has been positively identified as the carrier of the poison. It was the first time in thirty years that this phenomenon has been noted in the ocean north of Southern California beaches, where the same is caused for the most part by microörganisms which are free from the poisonous substances.

At once, on the appearance of the goniaulux masses, quarantines were placed on mussels and clams in California, as it was found that the poison had spread to some of the latter bivalves. It was the first time on record that the clams of the region were found to be hosts of the poison organism.

The twenty-one victims recovered, but the condition of at least one of the patients was critical for several days. Upon learning of the situation the State Department of Health, coöperating with the Hooper Foundation of the University, placed an immediate ban on the sale of all mussels and clams, and sent out sharp warnings to all health officers along the Coast. Water samples along the Coast have been ordered, and if these show no further evidence of the destructive organism, the quarantines will be lifted.

The goniaulux are active between May and September, and thereafter seem to decrease greatly in numbers and to become impotent, in so far as their poison activities are concerned. The organism is ingested by mussels and by certain types of clams, lodging in the intestines and liver. It is destroyed by boiling in a bicarbonate of soda mixture, and may easily be removed by the elimination of the dark portions of the bivalve meat.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 72)

lacking every qualification to practice medicine. The ones risking 'treatment' by charlatans seem to be in a class with those who give gypsies their money for planting to grow gold." (Santa Rosa *Press-Democrat,* November 12, 1937.)

Records indicate that last year 10,853 students took the mental aptitude test furnished by the Committee of the Association of American Medical Colleges to students anticipating entering medical colleges.

"Dr. John E. Baker, former Receiving Hospital surgeon, convicted of grand theft for participation in a 'fake accident ring,' this week was sentenced to San Quentin Prison by Superior Judge Frank M. Smith, who denied his application for probation. Counsel for Doctor Baker, after a motion for a new trial had been denied, filed notice of appeal. Judge Smith ordered that Doctor Baker's time on the two counts of grand theft and conspiracy, carrying from one to ten years each, run concurrently." (Huntington Park *Bulletin,* November 8, 1937) (Previous entries, April, July, September, 1937; December, 1928.)

". . . Facing trial next week for participation in the fake accident ring and for assertedly conspiring to solicit injury cases, contrary to law, are eight physicians. Each is charged with conspiring with white lawyers. Those indicted awaiting trial are: Doctors E. B. Liddell, M. C.

(Continued on Page 22)

Early serum treatment saves lives in

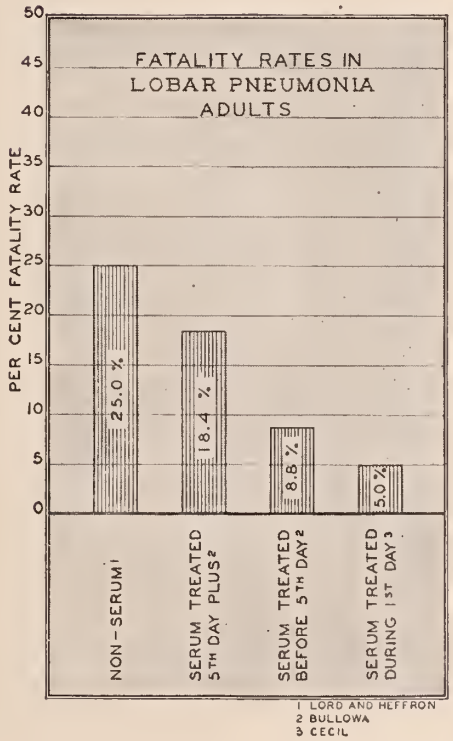
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The serum treatment of pneumonia is an emergency procedure. Delay may mean failure. Those physicians who have in mind where they can obtain prompt typing tests and a quickly available supply of specific serum are thereby assuring their patients the best chance for recovery and the shortest possible period of illness.

When adequate serum treatment is given early, lives are saved and complications prevented. When serum treatment is postponed and used only as a measure of last resort, it may occasionally prove effective, but it has often failed.

Bacteremia, a serious development, occurs with considerably less frequency in cases where early, adequate serum therapy is instituted.

Bacteremia appears at varying times in the course of the disease, but usually after the third day.



Bullowa* has presented the following significant facts concerning bacteremia in Type 1 and Type 2 pneumonias:

> In non-serum treated cases, the incidence of bacteremia is 25% in Type 1 and 43% in Type 2. The mortality in each of these bacteremias is close to 75% if serum is not used, and considerably lower when serum is used.

The importance of immediate typing, even at the first suspicion of pneumonia, cannot be overemphasized.

*BULLOWA, J. G. M.: "The Management of the Pneumonias" Oxford University Press, 1937.

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BOARD OF MEDICAL EXAMINERS

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Cooley, J. E. Porter, R. S. Whittaker, A. L. Wallace, C. D. Fredericks, R. B. Bledsoe, and W. B. Humphreys." (Los Angeles *Eagle,* November 11, 1937.)

"Jail sentences, fines and orders to make restitution were meted out yesterday in Superior Court to seven men and four women, members of a group of more than a score involved in a powerful 'fake accident ring,' which assertedly defrauded insurance companies out of thousands of dollars. All the defendants, except Dr. Frank Pearl, Negro physician, had pleaded guilty to various charges of grand theft, conspiracy and soliciting bribes, and appeared before Superior Judge Frank M. Smith seeking probation. . . . Doctor Pearl stood trial and was convicted of two counts of bribe solicitation. Evidence showed he bandaged and treated 'accident victims' who had no injuries and conspired with them to collect insurance money. Doctor Pearl was given a one year jail sentence and placed on ten years probation. Ten confessed they had entered into the insurance fraud conspiracies through the persuasion of George Dorris and Joseph Bone, who confessed to being the 'brains of the ring' and who are awaiting probation hearings with a score of other defendants. . . ." (Los Angeles *Daily News,* December 3, 1937.)

"Mrs. Adrienne Udstone, one of three defendants in Oakland's insurance 'racket' trial, took the witness stand yesterday to testify she was a victim of circumstances. Victim of the accident which was allegedly post-dated by Emile Grossman and Dr. Louis Kameny in an asserted effort to defraud an insurance company, Mrs. Udstone denied falsifying the date of the accident. She merely followed Doctor Kameny's suggestion to collect insurance on the accident because of its serious nature, she testified. Mrs. Udstone was assertedly burned in the beauty shop operated by Mrs. Anna Boggs in Oakland. Doctor Kameny previously testified he had urged collection of insurance on the burn and had altered the accident date on Grossman's suggestion. The prosecution contends the accident occurred previous to the date when insurance was taken out by Mrs. Boggs, that the trio of defendants conspired with her to set the date at a time after the policy was taken out. Trial is in Alameda County Superior Court of Judge Lincoln S. Church." (San Francisco *Examiner, East Bay Edition,* November 30, 1937.)

"In a surprise move, Dr. Ralph W. Bledsoe, well-known local physician, entered a plea of guilty Monday to a charge of soliciting the commission of grand theft, a felony, when he appeared with his attorney, Lloyd C. Griffith, in Judge Frank Smith's court. He was permitted to file an application for probation, which will be heard December 2. The charge grew out of the physician's asserted participation in an alleged fake accident ring. . . ." (Los Angeles *Sentinel,* November 18, 1937.)

"Dr. Leonard H. Larsen, '33, sailed for Spain October 20 to serve as physician and surgeon under the auspices of the Medical Bureau to Aid Spanish Democracy. He accompanied Dr. Edward Barsky, Chief of American Hospitals in Spain." (Stanford University *Illustrated Review,* November, 1937.)

The eyesight swindlers are gradually meeting well deserved punishment since the United States Post Office Inspectors have taken a hand in their procedure. Reports indicate that Frank Mackett, Jr., Attorney-at-Law, Milwaukee, was convicted on November 18, 1937, at Norfolk, Virginia, on a charge of fraudulent use of the mails in connection with the swindling of Miss Roberta M. Ridley of Boykins, Virginia, and was sentenced to a term of three

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BOARD OF MEDICAL EXAMINERS

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years. The records show that Mackett was previously convicted in Milwaukee and sentenced to a term of seven years and a fine of $2,000; however, the Court of Appeals set that verdict aside.

Matthew O. Wilkinson, eyesight swindler, who has operated in California and throughout the United States, is reported to have died at the Virginia State Prison Farm, November 4, 1937. (Previous entries, June and November, 1932; February, 1933; September, 1936.)

"Mrs. Edna G. Seward, operator of a local establishment for the cure of alcoholics, made it plain to Police Judge William J. Carraghar today she had found her most stubborn case. It was her husband and former partner, Ezra. Mrs. Seward testified as the complaining witness against him on a disturbing the peace charge. 'I tried everything to cure him, but nothing seemed to work as it did on other patients,' she said." (Associated Press Dispatch, dated Sacramento, November 16, printed San Francisco *Examiner,* November 17, 1937.) A similar report came to us some time ago regarding the manager of a well advertised treatment for alcoholism.

"Federal Judge A. F. St. Sure yesterday ordered condemned and forfeited to the government eighty-five pint packages and sixteen one-gallon bottles of elixir of sulfanilamide, after the required proclamation provided for seizures had been read in court. The deadly liquid had been taken from the warehouse of a local wholesale druggist. Despite the dangerous qualities of the elixir, the government, because of Drug Act restrictions, was forced to base its seizure on mislabeling. . . ." (San Francisco *Chronicle,* November 13, 1937.)

"Dr. Edward Peters, practicing Chiropractor of East Los Angeles, entered a plea of guilty to charges of violating Section 17 of the State Medical Practice Act of California and will come up for hearing on probation and sentence on November 16 in Whittier Justice Court. Doctor Peters, who pleaded not guilty and asked for a jury trial on October 15, last, was arrested on October 14 in Montebello Gardens, where it is alleged he carried on the practice of a physician without proper license." (Whittier *News,* November 4, 1937.)

"Dr. Max Hickok today was condemned to San Quentin prison. 'Five years to life' was the sentence imposed by Superior Judge J. J. Trabucco. The San Francisco chiropractor, convicted of second degree murder for the death of Mrs. Elizabeth Sowers, Oakland housewife, following an illegal operation, heard sentence pronounced without a flicker of an eyelash. But, back in his cell at the city prison, he broke completely. He sobbed half hysterically as he buried his face in his hands. At least ten days will elapse, however, before he must leave for San Quentin. His attorney, Alexander Mooslin, was granted a stay of execution of sentence in order that he might perfect an appeal. Previously his motion for a new trial had been denied. . . ." (San Francisco *Call-Bulletin,* December 1, 1937.)

"Trial of Mrs. Annabell McLellan, forty-one, and Mrs. Lucille Bouton, fifty-six, on illegal operation charges today was continued until January 5 by Superior Judge Edward J. Tyrrell. The continuance was granted when prosecutors from the district attorney's office sought to dismiss similar charges against Dr. Gordon McLellan, who committed suicide in his East Oakland home the day he was to have gone to trial. . . ." (Oakland *Post-Enquirer,* November 30, 1937.) (Previous entries, July, August, October, 1937.)

(Continued on Page 26)

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BOARD OF MEDICAL EXAMINERS

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"Suit for $1,250 damages was filed in Municipal Court yesterday by Mrs. Alma Roberts, radio station broadcaster, against J. Douglas Thompson, Oakland chiropractor. The suit alleges that the defendant promised to pay one cent per item for radio advertising of Doctor Thompson's beauty aids, said to have a sale of fifty thousand monthly. The complainant asserted that the monthly sale with radio advertising was represented to her as 193 and that she accordingly was given a check for $1.93." (San Francisco *Chronicle,* December 2, 1937.) (Previous entries March, 1928; February, March, April, July, 1936.)

"Suddenly dropping his move to fight a charge of violating the State Medical Act, R. B. Hartman, former San Bernardino chiropractor, pleaded guilty in justice court today and asked probation. Hartman, who will be released tomorrow from the county jail after serving 180 days for a similar conviction, will appear before Justice Russell A. Wickizer at 10:30 a. m. Tuesday for his probation hearing. Hartman pleaded guilty to practicing medicine without a license and admitted he gave medical treatment to a woman who was suffering from cancer. The woman was admitted to the county hospital where ten days later she died. Twice before Hartman has been convicted of medical act violation charges, once by a jury and the other time by the court. . . . Last January, Hartman was convicted of two charges of violating the state act and sentenced to 180 days in the county jail. He carried his fight for reversal of the verdict through the Superior, Appellate, and Supreme courts. Early in 1936, Hartman was convicted of similar charges and paid a fine of $180. After his conviction, the State Board revoked his chiropractor's license." (San Bernardino *Telegram,* November 26, 1937.)
"E. B. Hartman, former chiropractor, who was released from the county jail Sunday after serving 180 days for violating the State Medical Practice Act, was granted probation in the San Bernardino township court yesterday on a similar charge. Justice Russell A. Wickizer sentenced Hartman to serve 180 days on the last charge and suspended the term for two years on condition he does not violate any law in that period. Hartman pleaded guilty a week ago to a charge of practicing medicine without a license while he was at liberty pending appeals of his conviction of two charges of violating the State Medical Practice Act." (San Bernardino *Sun,* December 1, 1937.) (Previous entries, July, September, and November, 1935; January, March, April, 1936; August, November, and December, 1937.)

"Denial that he ever had authorized Henry Santrey to announce his candidacy for lieutenant governor at a meeting of the Exchange Club was made by Dr. Frank Nolan, Hollywood physician, (licensed by the Osteopathic Board), in a deposition on file today in the Municipal Court in the suit brought by Santrey and Guido Orlando to collect $2,000 for campaign services. The plaintiffs charged Doctor Nolan owed them the money for work they performed as campaign sponsors for his proposed candidacy for the lieutenant governorship. . . ." (Los Angeles *Herald and Express,* November 29, 1937.)

"Lowell W. Bird, forty, electrotherapeutist, who pleaded guilty before Municipal Judge Dean Sherry to practicing medicine in a downtown office building without a state license, today was serving a sixty day sentence in the county jail. Bird was arrested and charged with violation of the State Medical Practice Act following investigation of his activities by W. N. Anderson, inspector for the Board of Medical Examiners, who testified Bird ministered inadequately to several service men who came to him for treatment. Complaints from navy executive officers and the San Diego Better Business Bureau brought Anderson here to investigate the 'physician,' testimony revealed." (San Diego *Tribune,* November 26, 1937.)



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"A former Chicago physician appeared yesterday before United States Commissioner Ernest E. Williams, charged with violation of the Harrison Narcotics Act. He is known as Dr. John H. Trowbridge, forty-nine, reputed member of a prominent Beverly Hills family. He waived reading of the charges, indicated he would plead guilty as he twice before has pleaded guilty to Harrison Act violations." (San Francisco *Examiner,* December 4, 1937.) The name of John H. Trowbridge is not shown in the 1936 American Medical Association Directory, published by the American Medical Association.

"Three of four convicted members of a coastwide abortion ring yesterday were successful in winning new trials from the California Supreme Court. Rehearing of the cases against Valentine St. John, James Beegs and Jesse C. Ross was ordered on the grounds that a 'dearth of corroborating evidence' is apparently in the record of the trial before Superior Judge Arthur Crum of Los Angeles. A new trial, however, was denied a fourth appellant, William A. Byrne. Byrne attacked the indictment against him on technical, not evidentiary grounds. In all, twelve were convicted by the Los Angeles court. . . ." (San Francisco *Examiner,* November 27, 1937.)

"Warrants charging a Chicago doctor with criminally assaulting a fifty-year-old spinster as she lay on his operating table under the influence of a sedative were issued today against Dr. Jean Paul Fernel, a plastic surgeon. The warrants were issued on the complaints of Miss May Morrill, Worcester, Mass., spinster, who said she came here from the East, with her sister, Catherine, forty, to undergo facial beautification. The two Morrill sisters told the court of a harrowing tale of being imprisoned in Doctor Fernel's Michigan Avenue suite until they allegedly succeeded in escaping yesterday. Both appeared in court with bandages and scars, which they charge were the result of the surgeon's facial operations. . . ." (Press dispatch dated Chicago, November 27, printed San Francisco *Examiner,* November 28, 1937.) (Previous entry, October, 1927.)

"Facing charges in this city of violating the Medical Practice Act and petty theft, 'Dr.' Roy Cain, forty-nine, saw troubles piled higher for him with the receipt by the police of another warrant. The warrant from Berkeley was issued on a complaint which also charged petty theft. . . . The first two charges are declared an outgrowth of his prescribing for a local resident as a Chiropractor, without a license to so practice. Filing of the theft charge followed his allegedly obtaining a quantity of gasoline from a service station here and failing to pay for it. The Berkeley charge also was filed by a service station man, who alleges Cain gave him a worthless ring, claiming it was valuable, for a quantity of gasoline. It was reported Cain had been an inmate of Leavenworth, San Quentin, and Folsom prisons. Later check showed this also to be an error. He had been only in Leavenworth and Folsom. The Leavenworth term came as the result of a conviction in an Army Court desertion and escape from custody. The term in Folsom was served after conviction on a charge of issuing worthless checks. . . ." (Stockton *Record,* November 19, 1937.) ". . . Yesterday afternoon, after a hearing before Superior Judge D. M. Young, Cain was committed to the State Hospital. . . . " (Stockton *Record,* December 3, 1937.)

"Warning to all doctors against stock salesmen who claim ability to throw them compensation medical cases was given today by Clark B. Day, manager of the State Compensation Fund. Mr. Day has received reports that salesmen are approaching doctors with the whispered word that they have an inside track to the Compensation Fund." (San Francisco *News,* December 6, 1937.)

(Continued on Next Page)

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"Trial of Allan Mills, fifty-seven, of Paradise, who is alleged to have treated many Butte County persons with his 'radio impulse' machine, in violation of State Medical Practice Laws, probably will not be held until the middle of December. . . ." (Corning *Observer*, November 13, 1937.) (Prior entries, June and December, 1925; February, 1926; April and May, 1935; November, 1937.)

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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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CALIFORNIA AND WESTERN MEDICINE

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EDITOR GEORGE H. KRESS

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

A NEW-YEAR PRAYER OF TWENTY-FIVE YEARS AGO: BY PHILIP MILLS JONES, FOUNDER-EDITOR OF THE OFFICIAL JOURNAL OF CALIFORNIA MEDICAL ASSOCIATION

Dr. Philip Mills Jones.—Twenty-five years ago, in the *California State Journal of Medicine* (predecessor of CALIFORNIA AND WESTERN MEDICINE), appeared the Greeting for the year 1913, as penned by Dr. Philip Mills Jones, who had founded the Official Journal of the California Medical Association some ten years before. This New Year Prayer is again brought to light, and for several reasons: first, the thoughts therein expressed should have appeal for every physician who loves his profession, and their perusal should be an inspiration for continued service; secondly, it gives us opportunity to call to the attention of present-day members, who may not have known the late Dr. Philip Mills Jones, the splendid record of service and accomplishment he rendered to his beloved "Medical Society of the State of California" (the name by which the California Medical Association was then known); and lastly, because your present editor's early friendship with Doctor Jones permitted him to become intimately acquainted with a colleague who, like the late Dr. George H. Simmons, editor-emeritus of the *Journal of the American Medical Association,* through his broad vision and personality, left an indelible impress upon organized medicine in both his State and the Nation.

* * *

A New-Year Prayer.—We shall print first the New-Year Prayer, and then some excerpts from the pens of physician coworkers who tried to give expression to their regard and grief when, on December 3, 1916, during the influenza epidemic of 1916, death called Doctor Jones from his earthly labors.

* * *

Editorial Salutation in the January, 1913, Issue of the Official Journal.—The greeting in the *California State Journal of Medicine* of twenty-five years ago reads as follows:

†Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

A NEW-YEAR PRAYER

To all of our readers, Greeting! May the year deal kindly with you, and bring you much that is good and little that is of sorrow or trouble; may the spirit of peace and harmony prevail with you throughout the year, and may the mantle of jealousy drop from you as a rag that is worn out; may charity, justice, and brotherly love guide you always in your thoughts of, and your relations with your fellow practitioners of medicine; may it bring an end to bickerings and dissensions, and, departing, may the year leave with you a better-stored mind, contentment with yourself and your fellows, and the inward knowledge, from which comes peace of mind, of a twelvemonth of good, honest work, done with the very best that is in you, and to the betterment of at least a portion of mankind. Give of your time and your brains, the best you have to your medical society, that, in so giving, you may unselfishly help the entire medical profession and the people who are dependent upon it for health and protection; where there is an active and industrious medical society, there will you find good doctors and responsive and grateful patients. Let no word of idle slander or suppositious criticism of a colleague pass your lips; if you cannot speak well of a brother physician, speak not at all, for when you disparage another physician you hurt yourself as well, and the entire profession is belittled in the eyes of the people. May your interest in your medical society work increase with the passing months, and may the year close upon a more closely united and more intimately related medical profession, thus giving to the people of our State the very best medical supervision. May happiness be with you, one and all!

* * *

Tributes on the Occasion of Doctor Jones's Death.—In the October, 1937, issue of CALIFORNIA AND WESTERN MEDICINE, under the caption, "The Passing of a Great Editor: George H. Simmons, 1852-1937," editorial comment was made of the notable services rendered to the American Medical Association and its constituent units by Doctor Simmons. It may be added that all that was said of Doctor Simmons applies, in a general way, with equal force to Dr. Philip Mills Jones, and it is interesting and illustrative of the bigness of heart and outlook of these two men, who became pacemakers in medical journalism and medical organization work in America, that the surface antagonisms and warfare, which existed between them in their earlier years, gave place to a sincere and beautiful friendship when later opportunities permitted them to meet and work with one another; as happened in the many years when Doctor Jones represented California, not only as a member of the American Medical Association House of Delegates, but also as a member of the Board of Trustees of the American Medical Association.

* * *

An Unsigned Editorial.—Below appear first some lines from an unsigned editorial in the January, 1917, issue of the CALIFORNIA STATE JOURNAL OF MEDICINE, on the occasion of Doctor Jones's death:

DR. PHILIP MILLS JONES

"How few of us can do things that others cannot. Were you or I to die tomorrow, what difference would it make? . . .

"Work, that is the thing. And how few do work that others cannot; make things, do or write or say things that others cannot!

"It was strange to pass the State Society's offices; they had that look of the unknown that sudden and shocking events impart to the most ordinary and intimate objects. To hear a typewriter rattling and to think of him who used to dictate—to see files and stacks of letters, malpractice suits and judgments coming in, and to think of him whom they used so vitally to interest. To think that he had woven the JOURNAL, the Medical Defense, and all he had done to bring the profession together, to think of questions critically concerning them, and of what they meant to him—and to us—his work lying undone, and he caring no longer.

"Doctor Jones will be missed. Who is there to do his work? to combine law and medicine and organization talent; to bring to them an even and justly balanced intelligence, industry, and a knowledge of dealing with men.

" 'To be honest, to be kind'—yes—but more than that—'Work while it is called Today; for the Night cometh wherein no man can work.'

"The Night hath come, and we are groping for a guide."

* * *

Tribute from the Late Dr. Harry M. Sherman.—The quotations which follow are taken from a tribute written by the late Harry M. Sherman, beloved physician-surgeon of San Francisco, who in both the years 1914 and 1915 was president of the California Medical Association, sharing that honor of a two-year service with the late Dr. R. F. Rooney of Auburn (president, 1904 and 1905). Read now what Harry Sherman wrote of Doctor Jones's work in cleaning the pages of medical journals of two and three decades ago of off-color advertising, and of bringing about other reforms in organized medicine:

DR. PHILIP MILLS JONES

"It is still a strange thought to me that I have outlived Philip Mills Jones. In the little transient thought that I ever gave to the matter it was natural to think of him as sometime writing about me, dead—it seems almost unnatural for me to be writing about him, dead. . . .

"I came to know him and understand him best at and after this time of the starting of the JOURNAL. No one will doubt for a moment but that the JOURNAL as he left it to us, is the best criterion of the real Phil. Jones. It was never intended to be simply *a journal,* it was intended to be a particular kind of journal, and it has always been such. It has always had a distinct motive—has always followed a thought-out plan. Jones's interest in sociology has tinctured every word he ever wrote for it, and if one reads carefully it is easy to see it running through all his editorial paragraphs and articles. . . .

"Early in the history of the JOURNAL, that is, from 1903 to 1906—both inclusive—George H. Evans and I made, with Jones, a majority of the publication committee. Others who were on the committee with us varied from year to year, but the retention of us three during these four years made a continuous policy a practical thing. Our first big work was the reformation of the advertising methods of the medical press. I say "our first big work," taking to ourselves some of the glory, but Jones did all the writing, got all the obloquy and finally all the praise, while Evans and I merely backed and supported him. The crusade created much bitterness at first, and one famous editor was so much incensed at what was said about his journal that he would neither speak nor write to Jones, and when circumstances made it imperative that there should be some communication I was made the intermediary, the editor writing to me and I replying after consultation with Jones. This story would be most incomplete if I did not add that as time showed that the California contentions about advertisements were correct, the editor and Jones again became friends and were such to the end. It must be remembered that in this campaign Jones, actually single-handed and in a new journal with no established prestige, changed the advertising policy of every decent medical journal in the country; a great feat, for it cost many journals thousands of dollars to give up the profits of their reprehensible

contracts, and cull their advertisers as they did their contributors. . . .

"And then comes, in the December JOURNAL, his wish expressed to us for a Merry Christmas and a Happy New Year—and the jubilation that we are all alive, when he, dear man, is not—so that the wish—his last for us—comes to us, literally, from his grave, and we can all be most certain that, wherever the consciousness which we knew as Phil. Jones may exist, that wish is just as keen and living as it was on the day he wrote it for us to read it in this December."

* * *

California Medicine, scientific and organized, owes much to the late Dr. Philip Mills Jones* and the group of loyal officers and workers who, with him, laid the foundations for the California Medical Association of today, and Doctor Jones's "New-Year Prayer" of twenty-five years ago still applies with equal and even more force. CALIFORNIA AND WESTERN MEDICINE presents it in the hope that its warmth of feeling and breadth of outlook may be taken to heart, by each and all of us; for then, at the end of the year 1938, no matter what trials and tribulations may have come to us, we shall still remain stronger and better units in organized medicine.

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION: ITS PUBLICATION, "CALIFORNIA MEDICAL AUXILIARY COURIER"

Woman's Auxiliary Department of "California and Western Medicine."—Each issue of CALIFORNIA AND WESTERN MEDICINE presents, as one of its departments, "The Woman's Auxiliary to the California Medical Association," and we hope that the reports therein submitted are read not only by members of the Auxiliary, but by the California Medical Association members as well. It has been most interesting to note during the last several years, not only the steady growth of the Auxiliary through organization of new units, and consistent gains in membership in county auxiliaries already established, but also the record of increasing scope of work and influence.

* * *

Active Medical Practice Makes for Certain Limitations.—Let us be frank with ourselves. The responsibility of administrative endeavor in medical societies necessarily falls on the shoulders of a few members, the tendency being to let the physicians so elected or appointed bear the brunt of solving the problems so constantly coming to the front. In days gone by, with less social unrest than at present, the demands upon county medical society officers were not over-great, being limited at times to little more than preparation of programs for a certain number of scientific meetings to be held throughout the year. That condition, however, no longer obtains. Out of the air, almost, now come constantly new propositions to be faced, put forward sometimes, by well-meaning but poorly visioned organizations, but at other times, not infrequently, advanced by groups ill-intentioned from the outset toward the standards and advancement of scientific medicine and the public health. In short, the old order has changed, and it needs no deep study to convince an observing person that present-day menaces to scientific medicine will only be successfully overcome provided all members of the medical profession, as represented in organized medicine, and with the support of friends, will stand shoulder to shoulder, and give battle to those who, under whatever flag, would destroy medical practice as it has come into being through an evolutionary trial and error process. Granted that among the plans of theorizing visionaries and propagandists there may be here and there somewhat of merit, it still remains true, and is common sense, that in order to incorporate changes to overcome certain deficiencies in medical practice, it is not necessary and would be reprehensible to attempt reforms by revolutionary procedures that, in the end, would do more harm to public health interests than the good they were intended to or might bring into being.

* * *

Present-Day Turmoil of Economic and Social Unrest.—In the unsettled state in which the Nation is now trying to solve some of its economic and social-welfare problems, the theorizing propagandists have precisely the conditions favorable to the dissemination of their mouthings. To appreciate this, one needs only to glance through the newspapers and read between the lines, and observe how different is the portrayal of current news events than was the case a few years ago. The "free and independent press" of the present hour—believe it or not—watches, with keen eye, the trend of popular opinion, and, in contrast to days gone by, speaks kindly of this, that, or the other endeavor, when, not so long ago, the same matters would have received almost caustic editorial and reportorial criticism and comment.

* * *

The Lesson to Be Taken to Heart.—What is the lesson in all this, and what has it to do with the Woman's Auxiliary to the California Medical Association? Just this: Scientific and Organized Medicine need today every bit of their strength to successfully cope with the antagonistic influences directed against public health and medical practice. Most physicians, in the daily practice of their profession, have little time to sit in at service and other clubs where antimedical propagandists hold forth. Since, however, practically one-half of all clubs are women's organizations, it is understandable how representatives of the Woman's Auxiliaries to the California Medical Association, whose members take an active interest in the work of their literary, service and other clubs, can render most important aid in guiding aright, on public health and medical practice needs, the policies of such organizations.

* * *

State and County Auxiliaries in California Are on the Alert.—A perusal of the activities of the California county society auxiliaries, as given in each issue of the OFFICIAL JOURNAL, convinces one that the wives and daughters of California physicians are becoming increasingly

* For biographical data from *Journal A. M. A.* of December 2, 1916, see page 60 in this issue of CALIFORNIA AND WESTERN MEDICINE.

responsive of their own responsibilities in these matters. And it may be said, to their credit, that they are more than meeting their obligations. Wherefore, we welcome the messages brought to us in their semiannual publication, the *California Medical Auxiliary Courier,* and express the hope that, at some day not too far distant, the State Auxiliary will present to the California Medical Association Council for consideration, ample copy for a Supplement to CALIFORNIA AND WESTERN MEDICINE, in order that every member of the California Medical Association may note for himself what the gentler members of physicians' families are doing to promote the conservation of the public health and the advancement of medical science. If the California Auxiliary will continue to work in the future with the splendid discretion it has exhibited in the past, there must come to us all the wish that in due time—and not too far away—every county medical society of the California Medical Association will have associated with it a component county unit of the Woman's Auxiliary to the California Medical Association. Speed the day!

THIS AND THAT

Congratulations to Dr. Joseph P. Widney, Founder of the Los Angeles County Medical Association, on Attaining His Ninety-sixth Birthday.—December 26, 1937, was the ninety-sixth birthday of Joseph P. Widney,* M.D., D.D., LL.D., founder of the Los Angeles County Medical Association; founder also of the College of Medicine of the University of Southern California; co-founder of the *Southern California Practitioner;* ex-president of the University of Southern California, where, in the panic of 1893, as president, he pledged his personal resources to prevent foreclosures on the University's property; oldest living graduate of the University of California (Toland Medical College, 1866); an exemplar of the highest type of citizenship as manifested through years of consistent service; and a writer and author of half a dozen notable volumes, who only a few months ago, at the age of 95, brought off the press his latest book, "Civilizations and Their Diseases, and Rebuilding a Wrecked World Civilization."†

The career of Doctor Widney, who was born on December 26, 1841, has indeed been most remarkable, standing out as it does among his medical colleagues and fellow citizens like a beacon light to be seen afar by all who would chart their lives along lines of service and achievement. A bronze bust of the founder graces the rostrum of the auditorium of the Los Angeles County Medical Association headquarters building, there to remind members of that large component county unit how splendidly a life may be devoted to the service of mankind, both for todays of the present and the tomorrows of the future.

We extend to Doctor Widney, therefore, on behalf of the 5,700 members of the California Medical Association, our best wishes for the good health and happiness he has so richly earned, and urge a perusal of his latest book, from which some paragraphs are given below, for sober reflection upon the code which he long ago mapped out for himself as his own guide in his life work:

"I have never written for money. The sole object has been the carving out of broader lines for the human race. For more than fifty years of careful historical study, I have thought, and planned, and worked to this end. This ultimate purpose has run through all my publications. I have not placed upon the public market the books which I have written. I had not the time for this in an overworked life, nor have I had the means. My works have been placed, instead, in the great public reading rooms, and libraries, and colleges and universities of the world, where they might find the largest number of readers. This has drained heavily upon my private resources, so much so that I must still go on in the same old way. It is my contribution to the uplift of humanity and the making of a better world, and with this I am content.

"I am near to the beginning of my ninety-seventh year. Owing to injuries received in an accident, I have had to do all my work under the heavy handicap of being crippled, and in blindness, and in pain. Every word that I have published, for many years, I have had to dictate. What this means in patience, in difficulty, in labor, only one who has gone through it can know.

"There is still much that I have planned. Following the book now in the press ("Civilizations and Their Diseases, and Rebuilding a Wrecked Civilization"), there must come as a separate volume the work on the future of the Engle Man ("The Future of the English-Speaking Peoples"), to which I have made reference; thereafter, a book on "Life and Its Problems as Seen by a Blind Man at Ninety- —?—" In addition, there is other work which I need not enumerate. I had planned for a century; but this is in the Hands of One to Whom the centuries are only as a work-day. His will be done.

"Domine ad Te oculos cæcos levabo!"

* * *

Professor A. W. Meyer's Article.—In CALIFORNIA AND WESTERN MEDICINE for December appeared several articles concerning which comment may be made.

In the original article section, space was given to the scholarly discussion entitled "Use Destruction in the Human Body," contributed by A. W. Meyer, M.D., professor of anatomy at Stanford University. The facts therein outlined, based as they are on extensive and careful observations covering many years, and which are called, in conservative and scientific manner, to the attention of members, will have appeal not only to readers of CALIFORNIA AND WESTERN MEDICINE, but also to students of the subject, both at home and abroad. The contribution is a welcome addition to the literature.

* * *

District of Columbia and "Liberal Press" Articles.—In each issue of the OFFICIAL JOURNAL is a department given over to Special Articles,

* For biographical and other references concerning Dr. Joseph P. Widney, see CALIFORNIA AND WESTERN MEDICINE, April and May, 1936, pages 292 and 396.

† Review of this volume in CALIFORNIA AND WESTERN MEDICINE for December, 1937, on page 367.
Other volumes by Doctor Widney include:
Race Life of the Aryan Peoples, in two volumes. Pp. 698. New York: Funk & Wagnalls Company, 1907.
The Lure and the Land. Pp. 190. Los Angeles: Pacific Publishing Company, 1932.
The Genesis and Evolution of Islam and Judaeo Christianity. Pp. 238. Los Angeles: Pacific Publishing Company, 1932.
The Faith That Has Come to Me. Pp. 269. Los Angeles: Pacific Publishing Company, 1932.
Whither Away? Pp. 152. Los Angeles: Pacific Publishing Company, 1934.
The Three Americas. Pp. 306. Los Angeles: Pacific Publishing Company, 1935.

made up usually of a mélange of current-interest topics of such nature that physicians who desire to keep in touch with the trends in scientific medicine, disease features pertinent to California, or social welfare endeavors related to medical practice may find in their reading something worth while.

On page 433 of the December issue, for example, appeared an article, "United States Experiment in State Medicine Brings Protests," in which the story of what an agency of the Federal Government, the "Home Owners Loan Corporation—HOLC," is doing with public funds, by subsidizing, to the amount of twenty thousand dollars yearly, a coöperative clinic of federal employees. The HOLC maintains that it can thus use public funds to aid what in one sense is a private enterprise, because Congress, in order to permit the Home Owners Loan Corporation to do its major work, gave to that agency the status of a private corporation, vesting in its Board the legal rights of private corporations. It is stated that the District of Columbia Medical Association will take that issue into the courts, in order to have judicial opinion on whether public monies can be so used. The HOLC experiment is little other than an expression of state medicine, even though at the present time only two thousand employees are involved; and with comparatively little economic significance, perhaps, except as to principles involved. However, if the precedent so established were to be adopted by the many other federal agencies in Washington, D. C., with their thousands and thousands of employees, the matter would take on aspects of grave nature, not only to members of the medical profession at large, but to the entire tax-paying public of these United States.*

* * *

The "Liberal Press"—Excerpts from "The Nation" and "The American Mercury."—Readers who refer to the District of Columbia article may also be interested to peruse, on its opposite page, the item, "Two Articles of Interest in *The Nation* and *The American Mercury,*" in which quotations from those publications are given; *The Nation* excerpt being a good example of the bias which exists in publications of its type toward the American Medical Association, and its constituent state organizations and their component county units. It was a fortunate coincidence that *The American Mercury* of the same month contained a critical analysis of the publication, *The Nation,* and it may be in order to reprint here the last paragraph of the December excerpts, to call attention to opinions expressed by the contributor to *The American Mercury,* in which he emphasizes the menace to American standards and traditions inherent in the outpourings of certain "liberal publications." Whether we agree or disagree with the thoughts so expressed, the quotations as given in the December issue (on page 432) are still worth the time of perusal:

"Furthermore, it is probably accurate to say that, today, the *New Republic* and *The Nation* are the most effective amateur propaganda adjuncts to the American Communist movement. For the once liberal weeklies are, in a sense, the bridge between Communism and the unconvinced intelligentsia. Their 75,000 subscribers, by a process of natural selection, are vocational molders of national opinion. They are teachers, writers, clergymen, professional men and women, social workers—the picked middlemen of American intellectual life." . . .

* * *

"Public Health Liability Act—Proposed Initiative 29."—This is a proposed law known as Initiative 29, which suddenly came to the front when efforts were made to have the Public Health Committee of the Los Angeles Chamber of Commerce grant its approval to the measure. At this writing, we are still in the dark concerning its sponsors, both direct and indirect. However, who may or may not be the authors and promoters of the proposed law, for the enactment of which its sponsors are making an effort to have it placed, as an initiative measure, on state election ballots of 1938, is, in one sense, of minor concern at the moment. It is the viciousness and absurdity of the provisions contained in the proposed law that warrant its careful perusal by every licensed physician of California, and it is therefore printed in full, with some italicized phrases by the Editor, on page 66, in this issue of the OFFICIAL JOURNAL.

The proposed law, among other things, would make an error of judgment in diagnosis a crime; would destroy existing standards of healing-art practice; would make physicians guarantors of cures; would make patients' records public documents; would make hospitals (including charitable hospitals) and their nurses liable for the acts of physicians using such hospitals; and would define major surgery, minor surgery, practice of medicine, wrong diagnosis, and unnecessary major surgical operation in a manner which would effectively prohibit medical practice as it is now understood!

Members of the California Medical Association are requested to read this proposed initiative law and satisfy themselves concerning the nature of this stupid measure, which, in the interests of the public health and of scientific medicine, must be opposed wherever it may be presented for consideration.

The attention of the officers of the California Medical Association has been called to this most recent attack upon legitimate healing art practice. In the meantime, members of the California Medical Association are requested to be on the alert, and to forward any additional information to the central office of the California Medical Association.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 39.

* Note.—As the page proofs are about to go forward to the printer, we received a copy of a dispatch stating that the Acting United States Comptroller General had ruled the HOLC was without authority to loan $37,357.65 to the Group Health Association, Inc., of the District of Columbia.

EDITORIAL COMMENT†

EXPERIMENTAL RENAL HYPERTENSION

About ten years ago it was suggested by Farr[1] that the hypertension of Bright's disease is caused by renal ischemia secondary to nephrosclerosis. Doctor Goldblatt[2] and his coworkers of the Institute of Pathology, Western Reserve University, Cleveland, have devised an ingenious method to test this hypothesis, experimental renal ischemia caused by adjustable silver clamps placed about the main renal artery. The operation is performed retroperitoneally, with special instruments for the insertion and closing of the adjustable clamps. By this technique a "moderate" (30 per cent), "severe" (60 per cent), or "very severe" (90 per cent) reduction in renal circulation can be produced in experimental animals and maintained for several months or years.

Dogs, in which a "very severe" renal ischemia is so produced, show a rapid increase in systolic blood pressure, such pressure eventually reaching about twice the normal level. These animals soon show signs of renal insufficiency; urea nitrogen, nonprotein nitrogen and creatinin being increased in the blood stream. All animals with "very severe" ischemic kidneys die in about three weeks with typical manifestations of uremic intoxication.

Dogs, in which only "moderate" or "severe" bilateral renal ischemia is produced by this technique, usually survive the operation. Within from four to eight weeks a 100 per cent elevation in systolic blood pressure is usually noted, persisting with but slight change for at least fifteen months. Control experimental ischemias in other organs or parts of the body produced no significant hypertension in dogs. In the chronic renal hypertension the only subnormal renal function is a decreased "urea clearance"; blood urea, nonprotein nitrogen and creatin remaining within normal limits. The hypertension in these animals resembled that associated with so-called "benign nephrosclerosis" in man.

Two plausible explanations of the mechanism of renal hypertension were suggested by their findings: (1) a neurological theory, the assumption that afferent impulses from the nerve endings in the ischemic kidney to the sympathetic ganglia or vasomotor center might result in a general vasoconstriction and consequent elevation of systemic blood pressure; and (2) a hormonal theory, the assumption that the ischemic kidney gives off an unknown internal secretion, which by central or peripheral action causes a general vasoconstriction.

The neurogenic theory suggests that bilateral sympathectomy would prevent or cure renal hypertension. To test this conclusion, Doctor Goldblatt[3] and his coworkers excised the entire thoracic portion of the splanchnic nerves and the lower four dorsal sympathetic ganglion in four normal dogs, both sides being extirpated at the same operation. After full convalescence, renal ischemia was produced in these four dogs by their routine silver-clamp technique. In all animals typical hypertension developed in from four to eight weeks, and persisted for at least nine months, the animals being alive at the time of their report.

In a second group of dogs, renal hypertension had been produced from three to four years previously. Excision of the splanchnic nerves and lower four dorsal sympathetic ganglia caused no significant reduction in the renal hypertension in these animals. The authors conclude that "in dogs, excision of the thoracic portion of the splanchnic nerves and the lower four dorsal sympathetic ganglia, on both sides, does not prevent, cure or permanently lower in any degree experimental renal hypertension produced by renal ischemia."

To test the probable application of their results to human medicine, the Cleveland investigators[4] then attempted to produce a similar chronic hypertension in monkeys. Large, mature, young giant-type macaques were used. Blood pressure before and after the production of renal ischemia was determined by the Riva-Rocci method, the cuff being placed about the abdomen with auscultation of the femoral artery. An occasional control reading was made by inserting a hypodermic needle in the femoral artery and recording the "mean pressure" on a mercury manometer. In their most successful experiments both the systolic and diastolic blood pressure rose from the time of partial closing the second renal clamp. Maximum hypertension was reached by the end of about eight months, and has persisted till the time of their report (fifteen months). At the present time one monkey has a systolic pressure of over 300 millimeters of mercury, its preoperative pressure being in the neighborhood of 130 millimeters of mercury. The diastolic pressure in this animal had increased from the preoperative level of 90 millimeters of mercury to the present level of about 220 millimeters of mercury. The possible therapeutic effect of bilateral sympathectomy has not yet been tested in monkeys.

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CARDIAC SYNCOPE AND SUDDEN DEATH

Acute cardiac syncope remains one of the most difficult emergencies with which the physician has to deal. The difficulty lies in the fact that the situation appears so suddenly, and that it may be either acute block or ventricular fibrillation. It is not easy to tell promptly which condition is present. Since effective treatment depends on the diagnosis, great

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Farr, T., Handbch. spez. path., Anat. u. Hist., Berlin, 6:438, 1925.

2 Goldblatt, H., Lynch, J., Hanzal, R. F., and Summerville, W. W.: J. Exp. Med., 59:347, 1934.

3 Goldblatt, H., Gross, J., and Hanzal, R. F.: J. Exp. Med., 65:233 (Feb.), 1937.

4 Goldblatt, H. J.: J. Exp. Med., 65:671 (May), 1937.

skill is demanded in order to make a rapid decision and to act efficiently and wisely. California workers have made notable contributions in regard to the successful handling of either acute heart-block or ventricular fibrillation. Nathanson [1] of Los Angeles has made an especially clear analysis of the problem, and his work deserves full appreciation.

First carefully investigated by the English chloroform commissions, acute cardiac stoppage in anesthesia was shown in the classic studies of Goodman Levy [2] to be due chiefly to hyperactivity of the sympathetic system, with perhaps sudden adrenin release. In this situation ventricular fibrillation may occur. The clinical significance of this matter in anesthesia has been admirably discussed by Knoefel [3] and Guedel.[4] Knoefel makes the pertinent suggestion of using the barbitals in preanesthetic medication in order to prevent this type of syncope from developing. In an investigation particularly thorough, Nathanson has demonstrated that quinidin or acetyl-beta-methylcholin will prevent prefibrillation rhythm. Escamilla [5] has reported clinically on the use of quinidin in preventing transient ventricular fibrillation. The California group, therefore, emphasizes the importance of taking measures preoperatively to prevent ventricular rhythm from making its embarrassing appearance. This emphasis is certainly warranted, since effective treatment is difficult because of the acuteness of the situation once it develops. Certainly the etiology of ventricular fibrillation makes it clear that intracardiac injections of epinephrin are definitely contraindicated. Sensational newspaper reports of "bringing the patient back from the grave by injecting adrenalin into the heart" should decidedly not encourage surgeons to make intracardiac injections of epinephrin as soon as it may seem that the heart has stopped during an operation.

On the other hand, acute cardiac syncope may be complete heart-block resulting from excessive parasympathetic activity, either reflexly, as from pressure on the carotid sinus, or by central excitement and apprehension. In this situation atropin is well established as a method of paralyzing the vagal endings and preventing the acute block. The preoperative administration of atropin is definitely indicated for this purpose, especially in an apprehensive intellectual patient, who may give the impression of complete control of himself. This use of atropin is indicated in addition to its administration for preventing excessive flow of mucus. If acute heart-block does appear, Nathanson [4] has clearly shown that injection of epinephrin or its derivatives is the most effective means of getting the ventricles to beat again. These agents directly stimulate the cardiac accelerator mechanisms. It should be carefully remembered, however, that the very reasons for effectiveness of epinephrin in heart-block are the same for which it is contraindicated in ventricular fibrillation. If the heart stops in the early stages of anesthesia from vagal block, then intracardiac injections of epinephrin are justified, but if it goes into syncope from ventricular fibrillation, then epinephrin is contraindicated. How is the surgeon or anesthetist to tell promptly what the situation is? It is not easy, and for this reason it is wise to take proper preoperative measures to prevent either.

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1 Nathanson, M. H.: Effect of Epinephrin and Related Compounds on Induced Cardiac Standstill, Arch. Int. Med., 54:111 (July), 1934; Pathology and Pharmacology of Cardiac Syncope and Sudden Death, Arch. Int. Med., 58:687 (Oct.), 1936.

2 Levy, A. Goodman: Chloroform Anesthesia, pp. 95-100, London, 1922; Cardiac Syncope in Chloroform Anesthesia, Heart, 4:319, 1912.

3 Knoefel, P. K.: Anesthesia and the Sympathetic Nervous System, Anesth. and Analg., 15:137, 1936.

4 Guedel, A. E.: Inhalation Anesthesia: A Fundamental Guide, pp. 85-92, New York, 1937.

5 Escamilla, R. F.: Report of Case of Paroxysmal Ventricular Fibrillation in Relation to Quinidin Therapy, Amer. Heart J., 8:850, 1933.

THE UNPADDED PLASTER OF PARIS CAST

The use of plaster of paris or gypsum for splintage dates to the Arabian physicians [1] of the tenth century. Needed facility in handling of this plaster started a century ago when Mathijssen,[1] a Dutch army surgeon, promulgated the idea of impregnating cloth with dry plaster. In recent years the introduction of the fast-setting plaster has proved a tremendous advance. Originally, the gypsum casts were in massive blocks, but they have been evolved to the thinnest and lightest of all forms in the unpadded plaster type. The Austrian surgeon, Bohler, through his teachings has perhaps done most to promote this latter idea of splintage.

Those who are averse to plaster casts are apt to be doubly averse to the nonpadded type. A fracture axiom is this: "It is the doctor behind the splint, and not the splint that counts." [2] But given the use of proper details in the application of the unpadded splint, its wide field of application and its mechanical correctness should encourage enthusiastic adoption.

Air cushions are comfortable because pressure is distributed equally over wide surface, which makes pressure per unit area very small. A pillow of feathers is soft to the head for the same reason. If it were possible to make out of stone a perfectly fitting cast to the head, this "stone pillow, theoretically, should be quite as soft as feathers. A version of Pascal's simple physical law of the transmission of pressure is expressed in the statement that total force is equal to the product of pressure or weight and area. ($F = P \times A$). The principle finds a common illustration in the hydraulic press. With a given force, pressure will increase as the area decreases, and conversely pressure will decrease as the area increases. A well-fitted, unpadded plaster cast creates a maximum area with a resultant minimum pressure. Ill-fitting casts, padded casts, and the mechanical devices which offer support in re-

1 Bacon, L. W.: On the History of the Introduction of Plaster of Paris Bandages as a Fixation Dressing, Bulletin of the Society of Medical History of Chicago, 3:122-132 (Oct.), 1923.

2 Moorhead, John J.: Quotation from A. C. S. Coöperative Committee on Fracture, Traumatology, 1:2, 3 (April), 1933.

stricted surfaces, provide a limited area, creating thereby greatly increased pressure.

Early reduction of a fracture with application of an unpadded plaster cast completely surrounding the part will in many cases prevent swelling that would otherwise occur. Swelling that may occur following application of the cast usually is controllable by elevation of the part. At the outset the cases require watching to prevent and intervene if necessary, should signs of potential serious ischemia appear. A nonpadded plaster cast maintains fixation which cannot be promised in the padded type. In this latter splint it is practically impossible for padding to be uniform, and encircling bandages over the padding usually accentuate the lack of uniformity. An unpadded plaster of paris collar in the case of a cervical spine fracture, fitted carefully and extending down beneath the arms and over the upper chest, offers a "maximum area with a resultant minimal pressure." This type of splint is far more comfortable than the leather collars and other apparatus whose sole support focuses on a few square inches and thereby magnifies the local pressure. Padded casts for other parts of the spine or the extremities soon become loose, and the ill-fitting points of contact support the total pressure which becomes greatly amplified, but which would be minimal were surface available to dispose pressure widely and evenly. Poking cotton and packing beneath casts about pressure spots rarely is of value; on the contrary, very soon it creates a new pressure point or irritates an old one when the padding rolls into a wad and becomes displaced. The packing interrupts wide surface contact and multiplies pressure through diminishing contact area.

Success with the unpadded plaster cast depends on close attention to details in its application. When practicable, swelling should be dispersed before these casts are applied. When not practicable, old casts should be replaced by new ones when swelling has subsided. In applying the plaster, bandages should not be drawn tightly but lightly. Creases should be avoided. The plaster should be modeled; in doing this, pressure is not made with the finger tips but with the whole surface of the hand and with a force that disposes the plaster evenly. Fast-setting plaster is particularly desirable for successful modeling. Cut patterns of plaster for any part will often greatly aid in the ease and perfection of application. The patterns may be reenforced or united in their segments by the circular bandage of plaster. Modeling the plaster over potential pressure areas, such as the malleoli, the heel, the neck, the spine and joints generally, will meet with more success if small squares or units of plaster are used. Two by two inches represents a suitable size for many purposes. The smaller the part to be modeled, the smaller the square or strip of plaster should be that is used, if smoothness and evenness of application are to be achieved. Even such small parts as fingers may be splinted with unpadded plaster either for splintage itself or for purposes of traction. A case in point is a badly compounded fracture of the metacarpals with the whole hand considerably infected. Hazard of infection precludes skeletal transfixion through the phalanges. Small strips of plaster, one-half inch in width, would make in this case perfect nonpadded casts to the fingers that would be comfortable. Hooks for traction can be incorporated in the plaster. After drying, the plaster may be shellacked, the part set up in a banjo-splint, and wet dressings and irrigating solutions would prove to be practicable.

In summary it may be said that the unpadded plaster casts are comfortable because the wide surface of contact brings unit pressure to a minimum. Their use early in fractures following reduction minimizes swelling. These splints insure unchanging fixation and allow a patient quickly to become ambulatory. The combination of their beneficial qualities hastens bony repair and rehabilitation. They are not difficult to apply; they may be made light in weight and thin, and are economical. Success in their use, however, demands close attention to details in their application. Wide field of application, finish and, above all, mechanical correctness, will insure, it would seem, increasing adoption of the unpadded plaster of paris cast.

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LOCAL INJECTION ANESTHESIA: SOME ERRORS IN CONNECTION WITH ITS USE

A recent sequel to the injection of novocain and adrenalin leads to the presentation of the following unfortunate developments in connection with the use of novocain anesthesia locally.

In the above incident a man of seventy, definitely arteriosclerotic but without any evident peripheral vascular insufficiency, had the base of his right index finger injected with about 10 cubic centimeters of one per cent novocain, containing several drops of 1:1000 adrenalin. A tourniquet was not used. Incision was made for the cure of a paronychia. Three hours later the finger was cold and cyanotic, and the condition went on to a definite gangrene.

A woman of forty-five came to the out-patient department of a large county hospital, for the removal of a lipoma from the popliteal region. The tumor had been present for many years. The soft growth was the size of a fist, rather fixed, and seemed to infiltrate the underlying tissue. The overlying skin was prepared with iodin and alcohol, and a sterile towel placed near the field. Sterile gloves, but only a "clean" gown was used by the operator. A considerable quantity of one per cent novocain without adrenalin was infiltrated in and about the tumor, and an incision was made over the growth. Some difficulty was encountered in its removal, as it seemed to extend toward the knee joint in a branching fashion. A great deal of bleeding was present, and the assistance necessary for the proper exposure of the wound was not available. Finally, the tumor was removed; a Penrose drain inserted, and the wound sutured. On the patient's return two days later, the wound was

found infected. She was hospitalized, and most of the sutures removed. A definite cellulitis, however, had set in, and multiple incisions of the leg were found necessary. The infection did not clear up, but invaded the knee joint. After several months of drainage and disability, the leg had to be amputated above the knee.

A man of twenty-two had some vague complaints referable to the abdomen and an irregular, low-grade fever. The diagnosis was obscure. A palpable node was found in the left axilla, and it was decided to remove it for biopsy. The skin was prepared with iodin and alcohol, and the tissues infiltrated with one per cent novocain. A two-centimeter incision was made over the node. However, the gland proved to be elusive and was not easily found. An excessive amount of fat called for considerable dissection and more novocain. Finally, a bit of tissue believed to be the node was removed, and the wound closed without drainage. Two days later there was redness and tenderness at the site of the incision. A cellulitis developed and repeated incisions were made. Drainage continued for many months, and the end-result was a weak, atrophic left arm with a stiff shoulder.

From the above incidents it would appear that a more critical selection of cases for local novocain anesthesia should be made, and that:

1. In the aged, on extremities, adrenalin should not be used with novocain.

2. Minor surgery under local anesthesia should be treated with the same aseptic respect as major surgery, provision being made for adequate draping, assistance, and control of bleeding.

3. Either general or regional block, rather than infiltration anesthesia, is preferable where excess fatty tissue is present, or extensive dissection is done.

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ON THE FATE OF EPINEPHRIN IN THE BODY

Pharmacologists have long known that the effects of epinephrin, injected into the animal body, are quite transient—a fact which limits its therapeutic use.[1] Just what happens to epinephrin in the animal body is not known. The hormone is readily autoxidisable *in vitro* under the conditions of pH and temperature which obtain in the body, and it has often been assumed that the same mechanism is responsible for the inactivation occurring in the body. The recent investigations of Blaschko and coworkers[2] indicate that the *in vivo* inactivation of epinephrin is indeed due to oxidation, but that such oxidation differs in important respects from the course of events *in vitro*.

As a background for consideration of the inactivation of epinephrin in the body, the facts known concerning *in vitro* oxidation will be briefly outlined. The first oxidation product appears to be an orthoquinone. On further oxidation an indole derivative is produced, which is probably responsible for the pink color appearing in epinephrin solutions on standing. Complex oxidation and polymerization follow, some eight or nine atoms of oxygen being absorbed for each molecule of epinephrin present. Sympatheticomimetic activity is probably lost with the first step in oxidation.[3]

It is unlikely that autoxidation is the sole cause of inactivation of epinephrin in the body, since various substances present in blood and other body fluids and in tissue extracts serve to delay this reaction markedly. It is now known that amino-acids, guanidine, ascorbic acid (vitamin C), cystein, glutathione, and possibly other substances serve to inhibit the autoxidation of epinephrin. The rate of disappearance of epinephrin differs in different tissues—a fact which necessitates qualification of Elliott's statement that "adrenalin disappears in the tissues which it excites."[4] For example, no disappearance of the hormone occurred on perfusing blood containing epinephrin through the hind legs or lungs. The chief site of inactivation appears to be in the liver, kidney, and small intestine. Blaschko and coworkers[2] have shown that an enzyme system is present in these tissues which brings about rapid oxidation of epinephrin. This enzyme they have named "adrenalin oxidase." In accordance with earlier work, this enzyme was shown to be absent or present in very low concentration in skeletal muscle or spleen. There is no known reason why this enzyme system should not be operative *in vivo*. It is certainly suggestive that the organs in which it has been found are those which the earlier workers discovered were chiefly responsible for the disappearance of the hormone from the circulating blood.

The oxidation of epinephrin *in vivo* differs from that *in vitro*, not only because of the presence of this enzyme system in certain tissues, and because of the widespread occurrence of inhibitors of autoxidation, particularly sulphydryl compounds, but also in the fact that the total oxygen uptake *in vitro* is seven to eight molecules of oxygen per molecule of epinephrin, whereas the total oxygen uptake *in vivo* is but four atoms per molecule. This implies a quite different chemical picture.

Summarizing: The transient effects of epinephrin in the animal body are probably attributable to oxidation of the hormone through the action of "adrenalin oxidase." This event occurs chiefly in the liver, kidney, and small intestine.

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Success, in so far as it may be gained through training, is won by cultivating such powers and attitudes of mind as interests; the habit of observing and reading; expressing one's self through conversation and discussion, through speaking and writing; intellectual curiosity and study; freedom from superstition and prejudice; open-mindedness; and the ability to profit by experience.

ORIGINAL ARTICLES

MICRO-SURGERY IN CHRONIC SIMPLE GLAUCOMA*

By Otto Barkan, M.D.
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Discussion *by Robert Steele Irvine, M. D., San Francisco; Joseph Crawford, M. D., San Francisco; John C. Williams, M. D., San Francisco.*

THE writer has recently reported an operative procedure [1,2] for the relief of chronic simple glaucoma, which consists of opening Schlemm's canal under direct magnified vision. This procedure removes the block to the circulation of intra-ocular fluid which can be shown to be the mechanical cause of the increased intra-ocular pressure. It restores the physiological direction of outflow to the intra-ocular fluid instead of creating an abnormal outlet with its frequent complications and sequelae that may follow present-day operations. By means of a contact glass which has been devised for this special surgical purpose, the operator can see the area of blockage, and can watch and guide his instrument during the operation. The operative procedure when thus performed is without danger, and its objective, namely, opening of Schlemm's canal, can be deliberately performed with the trabeculum under full view. In those cases in which the trabeculum was incised over a sufficient extent, the intra-ocular pressure has returned to normal. According to observations during the last one and a half years, the results show promise of being permanent.

In this article an improvement of technique is suggested which will more certainly insure the opening of the canal. The original technique of operating under 4 x magnification affords a convenient range of some 20 centimeters and a fairly wide field. Because of the moderate degree of magnification, however, one cannot be quite certain of always striking the canal and of opening it over a sufficient extent in all cases. In those cases in which the canal was insufficiently opened, the intra-ocular pressure has been only partially reduced, and a later operation has been necessary to secure normal pressure. The technical variation suggested in this article consists of increasing the magnification from 4 x to 20 x. This increase of magnification is obtained by using the binocular corneal microscope attached to the surgeon's head by means of a helmet (Fig. 1). Although not easy of performance, the assurance of opening Schlemm's canal afforded by this higher degree of magnification would seem to be an improvement over the original technique in those cases where it is indicated.

MICRO-SURGICAL TECHNIQUE OF OPENING SCHLEMM'S CANAL UNDER DIRECT VISION

The surgeon wears a helmet to which is attached a binocular corneal microscope. He helps to steady



Fig. 1.—Photograph showing use of the binocular corneal microscope in author's operation of opening Schlemm's canal under direct vision.

the microscope with his left hand which, in turn, by means of a finger, keeps in contact with the patient's head. A trained assistant standing behind the patient's head for the left eye, and at his right side below the head for the right eye, fixates the bulbus at the temporal limbus with a small Elschnig forceps held in his right hand. With his left hand he steadies the surgical contact glass by means of a double-pronged probe which fits into two depressions on the convex surface of the glass. A second assistant guides the narrow beam of the hand lamp from across the bridge of the patient's nose to transilluminate the nasal portion of the limbus and the corresponding region of the angle of the anterior chamber. The surgeon supports and focuses the microscope with his left hand, while he guides the knife with his right hand. He sits on a stool adjusted to such a height that, by means of a slight movement of his head, his gaze may be directed first at the limbus and then transferred above the temporal edge of the contact glass to the anterior chamber, from which point he continues to guide the knife across the chamber by direct vision through the glass. When the blade reaches the highly magnified angle, its point is inserted exactly into that portion of the trabeculum which covers Schlemm's canal and the incision is continued for several millimeters along this line. That this may be accomplished with a high degree of certainty and exactitude is proved by postoperative biomicroscopic examination of the angle, which shows a single straight dehiscent slit of the trabeculum opening Schlemm's canal. What appears to be the glistening white inner lining of the opposite side of Schlemm's canal is clearly visible through this longitudinal bisection of its wall (the sclerocorneal trabeculum may be found to be bisected or sometimes torn off, constituting what may be called either a trabeculotomy or trabeculectomy, as the case may be). The working range is 6 centimeters

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

from the patient's eye to the tip of the objective, or 20 centimeters from the patient's eye to the eye of the surgeon. The image is kept in focus by the surgeon shifting his head, and for finer adjustment by using the sliding scale of the microscope, for which the fingers of the left steadying hand are used.

MICRO-GONIOSCOPE

The binocular corneal microscope has in the past been used by some ophthalmologists for the removal of foreign bodies from the cornea. This procedure I have found satisfactory in routine practice for many years, the patient sitting upright with his head on the chin rest. Recently, Schoenberg [3] has suggested its use for intra-ocular surgery, and reports attaching the head of the corneal microscope to a stand on a table, at the side of which the patient is lying, in order that it may be used in the course of surgical operations. He suggests that various uses are possible, but does not, as far as I can gather from reading his article, report having actually applied it to intra-ocular surgery nor proved its practicability for this purpose. Before reading his article such a use had occurred to me for my "micro-gonioscope," [2] which consists of a binocular microscope mounted on a highly flexible stand; however, the semi-rigidity of even this very flexible apparatus renders it unsatisfactory for purposes of intra-ocular surgery. It was for this reason that I divorced the microscope head from its stand and attached it to the surgeon's head where, with the additional steadying influence of the surgeon's hand, which maintains contact with the patient's head, it works out satisfactorily. Contact with the patient's head is found to be necessary if one considers that the slightest movement between microscope and object is magnified 20 x, and if one further takes into account the narrow breadth of focus and the limited field of vision when using this high degree of magnification. The field of vision, when using the 2 x objective and 10 x ocular combination is only 6.9 millimeters in diameter.

CONCLUSION

Examination of the living eye with the binocular corneal microscope is customarily called "biomicroscopy"; examination of wet specimens of the eye with the same instrument has been termed "micro-anatomy." [4] To operate within the living eye with this technique may be aptly termed intra-ocular "micro-surgery." As far as I am able to judge from a review of the literature, this is the first time that such high magnification has been applied in intra-ocular surgery.

The use of the binocular microscope, although it demands deliberate care and trained assistance, is feasible, and the procedure of choice when operating on Schlemm's canal under direct magnified vision in those occasional cases where extra assurance of striking the canal is required.

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DISCUSSION

Robert Steele Irvine, M. D. (490 Post Street, San Francisco).—That the results of the present treatment of chronic glaucoma are far from satisfactory can scarcely be disputed by anyone who will take the trouble to review his own records, or those of any clinic, where a fairly large amount of material is available. We frequently see these patients with a gradual loss of vision, despite our efforts, until the familiar and tragic white cane appears on the scene.

This paper of Doctor Barkan's is the summation of what he has written and done within the past three or four years, and presupposes some knowledge of the foregoing. It is an application, in a greatly improved manner, of the surgery of De Vincentiis, controlled by visualization through a contact glass such as heretofore had been limited to diagnostic purposes only in the attempts by Trantas, Koeppe, Frick, and Troncoso. He has set up definite conditions for its application, which enable him and us to determine its possibilities.

I have had the privilege of examining with Dr. Otto Barkan several of these patients, both before and after this microsurgery, and with his equipment the demonstration is not difficult and is indeed striking. I have also seen the operation performed, have seen the records of patients, over a period of two years, and have been impressed by the freedom from operative trauma, and the consistency of the results, as to the reduction of tension. The pigmented trabecular line can readily be recognized and incised under direct, magnified vision. There is no loss of aqueous, with the resultant plasmoid fluid, to further unbalance the mechanism.

Most of us are accustomed to working under high magnification, such as removing foreign bodies with a corneal microscope or slit-lamp, but unless this dexterity is present it does require unusual coöperation by the assistants and some skill, to avoid damage to the iris or scleral spur, or perforate the cornea. This is the reason for visual control throughout the incision. The difference between the arc produced by the knife, and that of the limbus must be considered.

This paper stresses the latest development in higher magnification, which, up to the point of too much narrowing of field or distortion, insures greater accuracy in placing and controlling the incision; a new field of surgery for which we should be appreciative.

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Joseph Crawford, M.D. (Medico-Dental Building, San Francisco). — Before discussing this modification of the author's operation for the relief of chronic simple glaucoma, by using a binocular corneal microscope attached to the surgeon's head, instead of an ordinary loupe, a brief description of the operation itself may be in order. If we accept the author's premise that the most frequent cause of chronic simple glaucoma is obstruction of the flow of aqueous from the anterior chamber into Schlemm's canal with a consequent rise of the intra-ocular pressure, any operation reëstablishing this function of that canal is indicated. Most of the operations used today for the relief of chronic simple glaucoma are external, filtering operations, in that they provide egress for the aqueous that is drained off imperfectly. De Vincentiis, in 1892, first suggested an internal incision in the iridic angle to reëstablish the normal route through Schlemm's canal; but due perhaps to the danger of the operation—for it was a blind one—it was not accepted generally. The danger is that of injury to the ciliary body, with resultant hemorrhage. Similarly other operations which are now also almost obsolete, such as anterior sclerotomy and internal sclerotomy of de Wecker, when they were effective in this type of case would appear

to have been so by virtue of their having struck the trabeculum on their way into the chamber. Otto Barkan first suggested the idea of incising Schlemm's canal from the inside while it is under direct binocular observation. He devised a contact glass which, when used with a loupe and a good source of focal illumination, makes it possible to incise the sclerocorneal trabeculum over Schlemm's canal while it is under full view. This type of internal filtering operation has much to recommend it, because it restores the physiological direction of outflow for the aqueous.

The magnification with a loupe is four times. Greater magnification is desirable. The binocular microscope increases the magnification to twenty times, but at the expense of working distance, breadth of field, and steadiness of image. Anyone who has tried removing a corneal foreign body under a slit-lamp can appreciate the difficulties of operating with these limitations. To perform such a delicate operation, as incising the sclerocorneal trabeculum with the microscope fastened to the surgeon's head, would make the operation too difficult for any but the most skilled operator.

While I have not as yet performed the operation, due to lack of a suitable contact glass, through the courtesy of Doctor Barkan I have had the opportunity of seeing a number of patients on whom he has operated. The results were so much better than one could expect from operations for the relief of chronic simple glaucoma that one cannot avoid being enthusiastic about its possibilities. Patients who had a persistently high tension with typical glaucoma fields before operation, had normal tensions for as long as a year after operation. The need for continued use of miotics had ceased. Amazingly enough, in one or two cases, there was an increase in the visual field. Most astounding of all was the fact that there was no visible evidence of an operation except by examination with the microgonioscope. The usual signs of a filtering operation, such as distorted iris, conjunctival scarring, bleb formation, etc., were lacking. Instead, an examination with the slit-lamp and contact glass revealed in the iris angle a long, gaping slit in the trabeculum, so well described by the author in previous articles. No one could see these postoperative results without the conviction that, at least in many cases of chronic simple glaucoma, surgical relief is possible and the operative problem is solved.

It appears to me that, for routine work, the operation is such an excellent and practical one that every eye surgeon will eventually use it in many, if not most of the cases of chronic simple glaucoma. By using the technique originally described by the author, the operation is feasible for anyone doing ophthalmic surgery.

John C. Williams, M.D. (490 Post Street, San Francisco).—The new method of approach of Dr. Otto Barkan to the study and alleviation of glaucoma has already given remarkable results and holds greater promise. As progress is made in the study of the micro-anatomy of the angle, refinements of technique will follow, and it is on this account that we view with such interest the application of high magnification not only to the study of the angle but, as we learn in this paper, also to the actual surgical procedure. On expressing my interest in his research, Doctor Barkan offered me the opportunity to study his methods and follow the results obtained. In two cases, I have followed the clinical course for a long period before the trabeculotomy, as well as afterward. Full control of the increased intra-ocular tension was never obtained under medical care, with the consequences that central and peripheral vision were gradually decreasing. After opening Schlemm's canal about one-fourth of its circuit, tension has been within normal limits without further use of miotics, and both central and the peripheral vision are improving. It is particularly fortunate in one of these cases that pilocarpin is no longer necessary, since the lids had become sensitized to its use. It may be said, in parenthesis, that miotics are used as a temporary measure after incision of the trabeculum to pull the root of the iris away from the angle until healing has taken place. This period of time is brief, for the after-reaction to this surgical procedure is remarkably slight. It would be feasible to repeat the operation if future time should show its necessity; but patients followed over a period of several months continue to maintain their improvement. In certain cases in which the glaucomatous process has not been fully controlled, it has been found that Schlemm's canal has not been adequately opened for a sufficient extent. Results of properly selected cases convince me that Dr. Otto Barkan's procedure in opening Schlemm's canal has proved a notable advance over existing methods in controlling chronic glaucoma. If the use of high magnification fulfills its promise of allowing this work to be done more accurately, it will be held a valuable addition to eye surgery.

Doctor Barkan (Closing).—I wish to thank the discussers for their contribution to the subject, and their words of appreciation. I have not yet seen any of these openings of Schlemm's canal close up. It is my impression that there is no tendency to heal over. However, the number of cases (twenty-five) operated on to date is too small, and the time elapsed too short to permit of any definite statement in this regard. In those instances where the incision has been insufficient and the result incomplete, it is possible to operate again. Operation is indicated in those cases which I have classified as Type I, and which are characterized by an open angle and a blocked trabeculum. There are also other cases, such as certain types of secondary glaucoma and hydrophthalmus, where the method is applicable. I am glad that the safety of the operation has been brought up, and that, in view of its being so safe, which cannot be said of any other glaucoma operation, one of its main applications may prove to be as an early operation. The operation can be performed by any well-trained and properly equipped ophthalmic surgeon. I expect that the latest model of the surgical contact glass, which was completed a few weeks ago, will prove to be the final one and should be available by you all within the next two months. I should like to take this occasion to suggest that anyone intending to do the operation should familiarize himself with the diagnostic set-up and with biomicroscopy of the angle of the anterior chamber before embarking upon the surgery of it.

PHYSICAL PHENOMENA ASSOCIATED WITH ANXIETY STATES: THE HYPERVENTILATION SYNDROME*

By William J. Kerr, M.D.
Paul A. Gliebe, M.D.
and
James W. Dalton, M.D.
San Francisco

Discussion *by Edwin L. Bruck, M. D., San Francisco; Mayo H. Soley, M. D., San Francisco; Samuel D. Ingham, M. D., Los Angeles.*

In the past several years, increasing emphasis has been placed upon the importance of the interaction of the physical body and the emotions. It is now realized that emotions may precipitate the symptoms of physical disease; and it is assumed that variations in the severity of a disease in a group of patients with the same illness can often be explained by variations in intensity of their emotional disturbances.

The most obvious instances of the interrelationship between emotions and disease have been found in the study of patients who have had secondary psychic manifestations which have necessitated consultation with a psychiatrist. However, there are less well-defined psychological disorders which underlie manifestations of disease; and these are

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less easily recognized. The internist is often called upon to make a diagnosis in cases where the patient's true illness is masked or simulated by symptoms which are the direct result of the emotional state of the patient. In some instances the symptoms imitate so closely those of a common illness that the disease is diagnosed erroneously, and a discouraging prognosis is given. This results in an obvious reaction on the patient. Already the subject of anxiety and burdened with emotions, he becomes overburdened by the added anxiety concerning his state of health.

A FUNDAMENTAL CONCEPT

To understand the reactions described above, it is necessary to accept a fundamental concept. The principle of psychobiology states that body and mind are indivisible, and that the body or physical structure without the mind is inanimate and has no human meaning. Whatever affects either the body or the mind at any time affects the individual as a whole.

Such a principle seems almost too obvious to be worth mentioning. However, it is stated at this time because too many physicians and surgeons, although recognizing its truth, continue to treat only the patient's body. When a patient's symptoms do not respond readily to treatment of organic disease, and evidence of anxiety is uppermost, the patient is classified as neurotic and is forthwith referred to another physician. However, more and more internists and surgeons are coming to recognize the importance of the relationship between mind and body; and, as a result, psychiatry is gradually losing its identity as a medical specialty and is, instead, becoming a new tool in the hands of internist and surgeon.

PSYCHOBIOLOGIC APPROACH

The psychobiologic approach, with its concept of the unity of the human organism, has served to widen the scope of psychiatric investigation. The immediate result of this more extensive investigation has been a deeper appreciation of the emotions of the individual. Comprehension of the importance of the emotions has been difficult because many physicians and surgeons have considered the indefinite symptoms, often complained of by patients, to be purely imaginary and without physiological basis. As a matter of fact, these indefinite symptoms have the same underlying mechanism as more physical manifestations, such as diarrhea and urinary frequency, which are not in any sense of the word "imaginary," and yet which may be caused entirely by disturbances of the emotions.

AUTHORS' STUDIES

During the past three years, several of us have been attracted to one phase of this problem because an increasing number of patients have appeared who were suffering from symptoms of tetany which could be explained only on the basis of hyperventilation. Also, patients have been seen in consultation who had definite symptoms and signs of organic disease, but who were suffering, in addition, from symptoms similar to those of patients who had been found to have hyperventilation tetany. Hyperventilation exercises and metabolic tests gave similar results for the patients in both groups, and all of them responded to the same type of therapy.

HYPERVENTILATION TEST

For the study of these patients, the hyperventilation exercise has been devised as a diagnostic procedure. In this test the patient is asked to lie on a bed without constriction from clothing, and to breathe at a rate of eighteen to twenty breaths per minute. Thus, hyperventilation is induced, which reduplicates or aggravates the patient's symptoms.

OTHER TESTS

In addition, the following tests were made on the patients of our series in order to rule out other causes of tetany, and to determine, if possible, whether or not a state of alkalosis existed: The reflexes were tested before, during and after the hyperventilation experiment. Before and after the exercise, determinations of the carbon dioxid combining power, chlorids, proteins (serum albumin and globulin), magnesium, calcium (diffusible and nondiffusible fractions) and phosphorus of the blood were made. The p^H and content of ammonium salts of the urine were estimated. In most instances, the basal metabolic rate was determined.

For all the patients in our series, similar results were obtained from these tests. The usual causes of tetany were eliminated. An alteration in the carbon dioxid combining power of the blood and a decrease of ammonium salts in the urine were found, which suggested that alkalosis was present. Since rather cumbersome methods were used at the time the studies were first made, it is possible that more marked changes had occurred followed by a partial return to normal before the samples were obtained. That such was the case is suggested by the results of later studies made by Doctors Shock and Soley,[1] who used a micromethod which is mechanically more adaptable. Their findings seem to indicate that the whole reaction is caused by tissue alkalosis, with the subsequent production of tetany or allied symptoms.

HYPERVENTILATION SYNDROME

Briefly, the train of events leading to the production of anxiety and the subsequent development of the hyperventilation syndrome can be described as follows: An individual has a difficulty to meet. The reaction, psychologically, may be one of two types: the individual may face his problem squarely and find a solution; or he may attempt to ignore the difficulty and to deny its existence. Regardless of any attempt on the part of the patient to deny the existence of his difficulty, nevertheless it still exists. In our opinion, it is the suppressed emotion associated with the difficulty that directly stimulates the autonomic nervous system. The sympathetic nervous mechanism is aroused, and the most outstanding reaction is a stimulation of secretion by the adrenals. The cerebral cortical centers are stimulated directly, and also by oversecretion of adrenalin. Adrenalin irritates also the cardiac and respiratory centers, causing at first a slow heart

rate with a large stroke-volume output, and later a rapid heart rate. There is speeding up of the respiratory rate and increase in ventilation. With the increase in ventilation the carbon dioxid in the alveolar spaces is expelled, and more is shifted from the blood stream and tissues into the alveolar spaces. Chlorids are retained in the blood, and phosphates likewise. Urea is not produced by the liver, hence ammonium salts are decreased in the urine. These later manifestations are the result of an attempt on the part of the body to prevent too great a shift to the alkaline side because of the sudden loss of carbon dioxid. However, the buffers that are mobilized do not entirely compensate for the loss of carbon dioxid, and as a result the patient suffers from the lack of sufficient acid ions and experiences irritability of muscle tissue because of alkalosis.

RÔLE OF ALKALOSIS

Some investigators[2] believe that the alkalosis does not explain the whole picture in this syndrome. They assume that the symptoms are caused by asphyxia, a lack of sufficient oxygen in the tissues. It has been stated that the attacks may be relieved by inhalation of oxygen without any carbon dioxid in the inspired gas. To a certain extent these conclusions may be true. Years ago[3] physiologists described the effect on the peripheral vascular bed of alkalies, oxygen, carbon dioxid, and acids; and of stimulation through the controlling centers in the central nervous system. It was found that acids and carbon dioxid, when applied locally, dilated the capillaries; when applied centrally, these vessels were constricted. In the study of patients suffering from the hyperventilation syndrome, both of these changes[4] in the peripheral vascular bed of the hands and feet have been found. Alternately, areas of cyanosis and redness caused by dilation of venules and arterioles, and areas of blanching due to arteriolar constriction, have been observed. These alterations in the condition of the vascular bed are sufficient to cause sensations in the skin through irritation of nerve-endings. Paresthesias have been described in nearly every instance.

SYMPTOMS OF HYPERVENTILATION SYNDROME

When the hyperventilation syndrome is present, a typical description of symptoms may be secured from the patient without much prompting. Some patients state that after a minor nervous reaction, epigastric discomfort is experienced, or palpitation followed by rapid heart rate. Sometimes there is a sense of constriction around the throat; and breathing deeply not only may fail to give relief, but may aggravate this symptom even to the point where the patient feels that he is suffocating. The patient, himself, or one of his relatives, may have noted that he is in the habit of sighing frequently, particularly when he is restless. Frequently the patient will be seen to gasp while describing his symptoms to the physician. Other symptoms that are often mentioned are stiffness of the hands and feet, dizziness, slight nausea, weakness and easy fatiguability. The sensations complained of are frequently described as severe or painful.

In many patients the hyperventilation exercise will reproduce all of the symptoms which have occurred during attacks. When carbon dioxid is inhaled from a small tank through a mask, with the patient continuing to breathe as during the exercise, these symptoms rapidly disappear.

Sometimes it is difficult for the patient to understand why small irritations now disturb him so much, whereas formerly considerable irritation was necessary to produce the marked sensations. The effect of adrenalin is that of increasing summation of nerve impulses; it has no effect on the chronaxie of the nerve. Because this is true, small or insignificant stimuli will in time cause protean manifestations. This is the reason why these symptoms can be induced in normal individuals by prolonged volitional breathing, although under ordinary conditions they do not have these sensations.

DIAGNOSIS

There are a number of common diseases, the symptoms of which are simulated by the hyperventilation syndrome. In an intensive study of thirty-five patients,* and observation of a larger group, a number of patients were found who had symptoms of precordial pain and rapid heart rate. Some of these patients were referred by physicians who had made the tentative diagnosis of coronary occlusive arterial disease or of aneurysm of the aorta or angina pectoris. When it was found that they reacted positively to the hyperventilation exercise, these patients were treated accordingly, and relief was obtained.

Other patients were seen who had suffered from symptoms suggesting Raynaud's syndrome. In these, spasm of the carpal arterioles was initiated by hyperventilation, and was relieved by the use of acid salts and an acid-ash diet.

There were several patients who had suffered asthma. In some of these an eosinophilia was noted. After all types of allergic reaction had been ruled out by skin tests and trials, the procedures described above were instituted, and successful therapy given.

Symptoms of peptic ulcer were found more often than those of any other disease. The Sippy treatment had aggravated the condition of these patients, for a very obvious reason. With the patient already bordering on a state of alkalosis, the addition of alkaline powders was more than enough to precipitate symptoms.

Other conditions with which this syndrome was confused were thyrotoxicosis and Mèniére's disease. Many of the patients with the former condition returned with recurring symptoms of thyrotoxicosis, following removal of an adequate portion of the gland. On examination, no objective findings indicated a return of thyrotoxicosis. These patients, likewise, responded to therapy directed toward the hyperventilation syndrome. In the group with Mèniére's disease, it was noted that nystagmus could be induced easily by the hyperventilation exercise; however, some one of the

*A detailed report of this study will appear in *The Annals of Internal Medicine.*

classical symptoms was usually lacking, *e. g.,* tinnitus, or loss of hearing. Ventilation with carbon dioxid immediately restored these patients to a normal condition.

It should be kept in mind that the danger of any unified diagnosis for several groups of symptoms lies in the use of such a diagnosis as a wastebasket for all uninteresting and obscure diagnostic problems. The value of an understanding of the hyperventilation syndrome is dependent upon the degree of diagnostic acumen of the physician. Failures and regrettable mistakes will be made if true organic disease is diagnosed as the hyperventilation syndrome. A case in point is that of a patient on our hospital service. This woman complained of tetany-like contractures of the hands, which occurred when she was excited. She was found to have hyperpnea, and some distention of the stomach by gas or air. She died in a second attack of tetany. An electrocardiogram made before death because the heart sounds were impure, but examined after death, showed the correct diagnosis to be coronary arterial occlusion, whereas a clinical diagnosis of the hyperventilation syndrome had been made.

The syndrome was here as a superstructure.

TREATMENT

An understanding of the problem is of great aid in the management of patients with the hyperventilation syndrome. The hyperventilation exercise shows to the patient the part he, himself, plays in the initiation of his symptoms. The reduplication of symptoms is a dramatic demonstration. Following this demonstration, an explanation can be made to the patient in simple terms. The patient is told that similar symptoms in other patients have been relieved by adequate control of respiration. He comes to realize that, with some help, he can relieve his own distress. He also feels that the physician thoroughly understands his problem. When this confidence is established, it is easy for more intimate contact to be made in order to institute psychotherapy, the success of which depends on rapport.

The prescription of acid salts, such as ammonium chlorid to the amount of 6 to 12 grams a day in capsules or in mixture of licorice, has been found to be of definite benefit. This regimen shifts the acid-base balance so that acid ions predominate. For immediate effect a phenobarbital compound may be used, but usually is not necessary. An acid-ash diet is to be given in all cases, and reduction of the intake of water is likewise of value. Some investigators have stated that the regular administration of the quinin drugs, hydrastin and yohambin, desensitize the nerve tissues to the continued action of adrenalin—which may explain the successful use of quinin as a "nerve tonic."

SUMMARY

It is the belief of the authors that many patients suffer from a group of symptoms which are directly traceable to the action, over a long period of time, of the emotions on the physical body. These symptoms are sometimes observed in association with those of organic disease. It is believed that such symptoms are the direct result of repeated overstimulation of the autonomic nervous system, which indirectly induces a state of alkalosis; and the alkalosis, in turn, aggravates the reactions already present and produces additional symptoms. The mechanism of the reactions is discussed, and a diagnostic procedure (the hyperventilation exercise) is described. The patients in whom this syndrome has been observed had complained of tetany or convulsions, or of symptoms simulating those of angina pectoris, asthma, peptic ulcer, thyrotoxicosis, Raynaud's syndrome, and Mèniére's disease. When the hyperventilation is found to be present, adequate treatment consists of instituting proper ventilation, the use of acid salts, such as ammonium chlorid and of an acid-ash diet, and the removal of the underlying anxiety by psychotherapy.

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DISCUSSION

Edwin L. Bruck, M.D. (384 Post Street, San Francisco).—For the last several years we have been interested in the symptoms presented by a small number of individuals, who have been usually characterized as neurotics. Many times these persons present themselves with the story that they are nervous, and that they have tingling and numbness of the four extremities, with occasional cramping of each of the feet or hands or both. Many times they may have also circumoral tingling.

When this train of symptoms is obtained in the history taking, they can be usually brought out in an exaggerated form or reproduced by the hyperventilation test as described by the authors. Most unusual symptoms may be produced in susceptible individuals with this test.

One may easily prove that such symptoms may be lessened or stopped through the rebreathing of carbon dioxid by the simple expedient of having the patient breathe and rebreathe into a large paper bag. Psychic origin of this chain of events cannot be denied in some cases, as they often appear in a hypertonic individual suffering from an anxiety neurosis.

However, the anxiety neurosis is not a necessary forerunner of this symptom-complex. Overbreathing from any cause will contribute to it, as in one patient of ours who could bring about the entire chain of events, even to the point of cramping in the hands, by a protracted spell of laughing.

There is, however, a chemical reason for production of these symptoms, often a self-induced alkalosis by the overindulgence in alkaline medications, usually brought to the attention of the laity through overzealous radio advertising. Likewise, the loss of chlorids, either through diuresis, sweating, vomiting or diarrhea, may produce a border state from which the individual is easily thrown into alkalosis, by minor overbreathing, giving rise to the usual symptom-

complex. It is also of interest to note that tissue hydration produced by intake of large amounts of water in susceptible individuals may produce some effects similar to those of alkalosis. Dederding and Fürstenberg have elaborated on this problem in their outlines of treatment of Menière's syndrome.

The authors have brought to our attention, forcibly, new criteria for the diagnosis of the alkalotic state, and have suggested efficient and simple modes of therapy which, in their hands and in ours, have produced beneficial results.

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Mayo H. Soley, M.D. (University of California Medical School, San Francisco).—Most physicians seeing consultation cases realize that two-thirds or so of their patients will have symptoms not directly related to any organic disease. Few of these physicians, however, have attempted to correlate the symptoms in their patients with the physiological effects of anxiety. Cannon, as long ago as 1915, demonstrated the effects of emotions on humans as well as on experimental animals. Since that time the spastic colon and hyperventilation syndrome have been added to the already recognized physiological effects of anxiety. The explanation that the symptoms of overbreathing are real, and can be reproduced, and that they are based on a fear mechanism, gives us a new and sound approach in the therapy of patients suffering from this condition. The intensity of the symptoms predominating in one system often makes the diagnosis difficult, but this predominance can be explained by the patient's fear of disease of that system with consequent exaggeration of sensations which he believes arise there. Usually, however, all of the characteristic symptoms from overbreathing can be obtained without asking leading questions, and point one to the correct diagnosis.

It should be stressed that treatment of patients suffering from anxiety states complicated by the hyperventilation syndrome with sedatives, acidifying drugs and diets, is merely a temporary measure to carry the patient along comfortably, while psychiatric investigation of the underlying fear is undertaken.

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Samuel D. Ingham, M.D. (727 West Seventh Street, Los Angeles).—Phychiatrists are encouraged to observe that internists are showing more and more interest and appreciation of psychiatric problems and their intimate bearing on the problems of internal medicine. It has long been realized, but not widely appreciated, that emotional states are invariably accompanied by characteristic variations in the functions of the vegetative nervous system, and the widespread physiological and biochemical reactions that result. It is still impossible, however, to reduce these reactions to simple formulas or to correlate them accurately in clinical analysis. We know, in a general way, that the acute emotional reactions run parallel to increased activity of the orthosympathetic, and inhibition of the activity of the parasympathetic systems. We know less, in fact very little, in a quantitative way, of the biochemical effects of the more prolonged or chronic emotional states, or moods, such as anxiety, grief, and the depressive states. This problem includes the evaluation of the physiological changes which may be observed in relation to the circulatory, respiratory, gastro-intestinal, genito-urinary, and endocrine systems; of the biochemical processes incident to each of the physiological changes and of their interrelations, and of the progressive effects of prolonged action of these processes which result in malnutrition, deranged endocrine balances, and even actual pathological tissue changes.

The problem also includes the analysis of the individual patient in terms of heredity, constitutional type, environmental experimental experiences, general health, and his immediate personal problems, which may be the cause of his emotional state.

It is probably true, as the authors suggest, that when the internists have solved these problems, the specialty of psychiatry will have lost its identity; but the internists will then have more on their hands to do than to correlate physical findings with laboratory reports, if they do their full duty to their patients!

DIABETIC SURGERY*

A TEN-YEAR SURVEY

By Irving Wills, M.D.
and
P. A. Gray, M.D.
Santa Barbara

Discussion *by Emile Holman, M. D., San Francisco; William C. Boeck, M. D., Los Angeles; James B. Graeser, M. D., Oakland.*

THE hazards attendant upon surgery in the diabetic patient in the pre-insulin era were such as to cause the surgeon to approach procedures of any nature in this group of patients with grave misgiving. That potential hazards still remain cannot be questioned, but the great advances made in the understanding of the physiology and chemistry of this disease have effected improved methods of treatment and have done much to dispel earlier fears and to furnish a satisfactory solution to the problem.

MATERIAL REFERRED TO IN THIS REPORT

In presenting this survey of diabetic surgery carried out in a small community, it is our purpose to point out the value of close coöperation between the surgical and medical departments, and to express our firm belief that success in the management of the surgical diabetic patient is largely the result of such coördinated effort.

During the ten-year period from January 1, 1927, to January 1, 1937, a variety of surgical procedures have been practiced upon a large group of diabetic patients. In all, 177 (Table 1) operations have been done on patients selected from the Metabolic Service of Dr. W. D. Sansum at the Santa Barbara Cottage Hospital and the similar service of one of us (P. A. Gray) at the Santa Barbara General Hospital. These patients represent a cross-section of private and charity clientele, showing all grades of severity of diabetes, and the operations performed are a cross-section of those to be encountered among such a group of patients.

PREDISPOSING SURGICAL FACTORS

It is a well-known fact that surgical conditions arise in the diabetic more often than in the non-diabetic patient. Among the factors responsible for this are (1) the age of the patient, (2) increased susceptibility to infection, (3) the frequent occurrence of acidosis, (4) delayed healing, and (5) cardiovascular-renal disease. In other words, the diabetic patient not only is liable to any disease to which anyone else in his age group is subject, but also, because of his diabetes, has a pronounced tendency to gangrene and infection. We feel, therefore, that the apparently higher mortality in this type of surgery is not due to the disturbed metabolism *per se;* and that diabetes adequately controlled should not materially influence the surgical risk. This belief has been borne out not only in our experience, but also in that of surgeons in the larger clinics.

* Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

TABLE 1.—*Operative Procedures—1927-1937*

Major		Minor	
Amputations	30	Tonsil	63
Abdominal:		Tonsil and adenoid	11
Pelvic	19	Carbuncle	7
General	16	Cataract	3
Urologic	7	Antrum	3
Breast	4	Various	6
Thyroid	3		93
Perineal	4		
Chest	1		
	84		

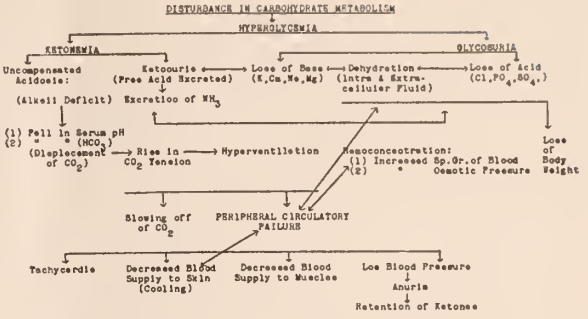


Chart 1

IMPORTANT SYMPTOM COMPLEX

Although this paper is not concerned primarily with surgical diagnosis, mention should be made of a diagnostically important symptom complex peculiar to the diabetic. While the student of diabetes is well acquainted with the picture of the "acute abdomen" simulated by diabetic acidosis, the general surgeon has little opportunity to study this interesting picture. Beardwood [1] and Baker [2] have recently reviewed this syndrome. Diabetic acidosis may produce a clinical syndrome resembling exactly the "surgical" abdomen, with nausea, vomiting, localized rigidity, fever and leukocytosis and, upon occasion, pyuria and hematuria. Case 1, cited below, is an illustration in point. This phenomenon has been explained upon several bases: (1) a sodium chlorid deficiency, (2) acute pancreatitis, (3) reflex irritation from spinal centers, and (4) gastric dilatation. Of these four hypotheses, the first has impressed us most. The symptoms described can be reproduced by states of dehydration and mineral deficiency paralleling those known to exist during diabetic coma. Relief of the abdominal pain has followed the intravenous administration of normal or hypertonic saline solution before the acidosis has been eliminated or the blood sugar lowered.[3]

Since diabetic acidosis alone may simulate a variety of surgical conditions in the abdomen, and since coma may equally well be precipitated by a pyogenic process in the abdomen, the differentiation between primary and secondary coma in a patient presenting abdominal symptoms becomes a nice diagnostic problem. The risk of operating upon patients in acidosis is such as to deter the surgeon from immediate operation, even though the patient may be admitted with abdominal symptoms. Almost any surgical condition, even a ruptured viscus, will permit of an hour or two delay. In this interval energetic treatment with fluids, sodium chlorid, glucose, and insulin should reduce the ketosis. If after a reasonable period there has been no change in the abdominal picture, or if it has become worse, exploration of the abdomen is justified. If, however, the nausea and vomiting have ceased, the abdominal pain and rigidity have vanished, and the fever subsided, surgery may wisely be postponed.

Since the leukocytosis may be due to hemoconcentration, estimation of hemoglobin and red-cell count, as well as the leukocyte count, should be made on admission and at frequent intervals thereafter. As the patient's water balance is restored with fluids, the total white count should fall. If it does not, we regard this as evidence of infection.

Table 1 shows that 177 major and minor operations have been done. The majority of the majors have been done by one of us (Irving Wills) and his surgical associates. This group will be considered predominately in this report. Especial consideration will be given to the groups of amputations and laparotomies.

PERIPHERAL CIRCULATORY COLLAPSE

From the metabolic viewpoint the gravest risk involved in diabetic acidosis is peripheral circulatory collapse, or so-called "medical shock." Peters [4,5] and Atchley [6] and their associates have studied the biochemical changes occurring in diabetic acidosis in elaborate detail. Lande,[7] Lawrence,[8] and others, have contributed to our knowledge of this clinical picture. Moon [9] has discussed the fundamental physiological unity of both medical and surgical shock. Understanding of the chemical and physiological processes involved will not only facilitate the management of the patient in diabetic coma, but also arm the surgeon against the complication of vasomotor collapse. The studies cited have shown fairly well that the clinical picture of shock results from a discrepancy between the volume of the vascular tree and the blood which it contains. In diabetic ketosis this discrepancy is due to the reduced blood volume consequent to the extreme dehydration. (Chart 1 illustrates the sequence of events diagrammatically.) Dehydration, hyperventilation, and cooling contribute to peripheral circulatory collapse. The first of these three factors can and should be combated by large volumes of fluid, preferably saline, to restore the depleted mineral base, which fluid can be given intravenously. Whole blood or acacia solutions, with their higher osmotic pressure and, hence, less likelihood of escaping through the capillaries damaged by anoxemia, may be preferable in emergencies. The second factor will disappear as the alkaline reserve is raised, and the third factor can be combated by the external application of heat. The patient's blood pressure is an excellent and simple clinical guide to the presence or absence of peripheral circulatory collapse, and should be incorporated into the routine care along with the blood sugar and CO_2 determinations. As already noted, we have recorded it at frequent intervals in all cases. Since the fundamental metabolic defect in this picture is dehydration, adequate amounts of fluids intravenously are freely justified.

AMPUTATIONS

The subject of amputations will always occupy a place of primary importance in diabetic surgery because of the frequency of gangrene and infection. These complications will probably remain prevalent because of the high incidence of arteriosclerosis, and the fact that a fairly large number of mild cases of diabetes go unrecognized and untreated year after year. In the surgical treatment of gangrene we see no particular advantage in making a distinction between the dry and the moist varieties, aside from the fact that the dry type usually does not present such an acute problem. To consider this type as uninfected is likely to invite trouble. It has seemed more rational to consider both types of gangrene as potentially infected, to determine if possible the presence or absence of septicemia, to examine the extremity carefully for signs of lymphangitis, and to suit and time the operation to the conditions present.

A high amputation has been the operation of choice in most of the cases. The advanced age of most of the patients, coupled with the inadequacy of their circulation, as demonstrated by oscillometric readings, makes this apparently radical procedure the one of choice.

Although most of our amputations have been through the mid-thigh, we have come to favor for selected cases the Callander modification of the Stokes-Gritti operation. This procedure possesses certain definite advantages, in that it neither exposes nor injures the muscle bellies, thus reducing the probability of infection. Furthermore, it gives a good weight-bearing stump without the necessity of uniting the patella with the end of the femur, as is the case in the Stokes-Gritti operation. In infected cases, showing advanced lymphangitis, a guillotine amputation above or below the knee may be a definitely life-saving procedure. It is our opinion that the patient's ability to walk later should not be given too much consideration when an amputation is contemplated. The life expectancy of many patients suffering from gangrene is short at best, and this fact, coupled with the increased risk of a subsequent higher amputation, does not justify the attempts often made "to save as much as possible." For those patients who are otherwise able to use it, a satisfactory prosthesis can be obtained to fit the high amputation stump. An analysis of the subsequent course and life expectancy of the patients in this group will be presented in a later communication.

The elaborate preparation of the leg for amputation has received considerable attention by various writers. We have been opposed to any active scrubbing or manipulation of the part, feeling that the milking action incident to vigorous cleansing may tend to spread bacteria from the unclean zone into an otherwise clean area. Our practice has been to cover all but a minimum amount of skin at the site of amputation and prepare this area with a generous coating of tincture of iodin. No other preparation has been used or considered necessary. The tourniquet has never been employed because of its devitalizing effect on the tissues and of the tendency to late oozing. By working as a team, the surgeon and his assistant can control hemorrhage so that only a relatively small amount of blood will be lost. Drainage, which was formerly used routinely, has not been employed recently. The wounds have been closed loosely with only a few interrupted sutures in the fascia and silkworm in the skin.

No special diabetic preparation other than control of ketosis when present has been necessary for those patients about to have an amputation. An adequate amount of fluid by mouth or hypodermoclysis has been insisted upon. Since about half of the amputations have been done under spinal anesthesia, especial check upon the blood pressure has been kept postoperatively. The first regular meal hour after operation has usually been omitted; thereafter the usual diet, converted into soft foods and liquids, has been served. Insulin has been given on a four-hour schedule, the amount depending upon the blood sugar, which should be kept between 100 and 150 milligram per cent.

LAPAROTOMIES

Most of the laparotomies performed have been elective and, needless to say, on patients that have been carefully selected. These patients have represented, for the most part, individuals from the "middle class" who have been under continuous diabetic supervision. In acute abdominal conditions, such as appendicitis, the importance of early operative interference cannot be stressed too greatly. Control of diabetes is difficult in the presence of acute infection, and the insulin requirement is temporarily increased. Drainage of the wound has been effected in these cases the same as in nondiabetic patients.

Whenever possible, laparotomy patients have been hospitalized several days prior to operation. Normal blood sugar levels have been considered desirable, but have not always been practicably obtainable. No patient has been allowed to go to surgery with a CO_2 level below normal. Fluids have been forced the day or days prior to operation, and 5 per cent glucose in normal saline solution has been given by hypodermoclysis the morning before surgery. (Table 2 shows the type of anesthesia which has been selected in this group of patients.) After the operation the patient's blood pressure has been taken at hourly intervals, the blood sugar determined at two hourly intervals (usually by the Folin-Wu method on capillary blood), and the urine tested whenever available. Because of the risk of infecting the bladders of diabetic patients,[10] we have refrained from catheterizing the bladder for the purpose of obtaining specimens.

On the first postoperative day a minimum of 3,000 cubic centimeters of fluids have been administered by vein or hypodermoclysis. At least 100 grams of glucose have been given as 5 per cent glucose in sodium chlorid solution the first twenty-four hours. A sufficient amount of insulin has been given to hold the blood sugar between 100 and 200 milligram per cent. Patients whose stomachs or bowels have been incised have received nothing by mouth for forty-eight hours. Others

Table 2.—*Anesthesia Selected*

	Spinal	Gas-Oxygen	Gas-O_2-Ether	Local	Ether	Gas-Amytal (Ether)
Abdominals General	4	2	5	3	1	1
Pelvic	2	3	11		2	1
Amputations	12	10	9	3		3

have received fluids (water, ginger-ale, sweetened tea, and water-packed pear juice, flavored with lemon) on the second day. Also on this day skim milk and white of hard-cooked egg have been given to some patients. On the third day, broth and junket have been added. On the fourth or fifth day, pureed bland fruits and vegetables, rice, potatoes, and melba toast have been permitted. Postoperative "gas" pains have been no more troublesome in this group of patients than among the nondiabetic group. The total calories fed per day have not exceeded 1,500 in any case as long as the patient remained at bed rest.

Each day enough fluid has been given to equal the volume of the twenty-four-hour urine specimen, plus 1,500 cubic centimeters (to allow for perspiration). In the more severe cases, insulin has been given every two hours in doses of five and twenty units; in the milder ones, every four hours in similar doses.

Preparation of the skin for laparotomy has been the same as for the nondiabetic patients, and since we have only one instance of wound infection (in the County Hospital), our technique may be assumed to have been adequate.

Included in this group of patients are four instances of cesarean section (done on primiparae) by Dr. L. F. Eder. Three of these included sterilization. There has been no maternal mortality, and only one fetal death from a congenital cardiac anomaly. The postoperative course of these four patients presented no unusual surgical problems. Control of their diabetes was maintained by capillary blood sugar determinations at two-hour intervals.

No surgical mortality has been encountered among the thirty-five patients who have undergone laparotomies. All left the hospital in good condition. Some have died since from causes unrelated to the surgical procedure practiced.

ANESTHESIA

Anesthesia is a subject about which there has always been considerable diversity of opinion, but with a better understanding of the action of the various anesthetic agents on carbohydrate metabolism those experienced in the surgery of diabetes have come more and more into agreement in the past few years.

Procain preparations, whether used intraspinally or as local infiltration, apparently have no deleterious effect on metabolism. Nitrous oxid and ethylene interfere in the carbohydrate metabolism, as shown by elevation of the blood sugar, accumulation of lactic acid in the blood and reduction of the alkali reserve of the blood.[11] However, these changes are slight if the duration of the anesthesia is not prolonged. Although nitrous oxid combined with ether produces even more marked changes, it may still be used safely if steps are taken to combat the ensuing acidosis. Ether should be used sparingly upon the diabetic patient. Although desirable from a chemical point of view, local infiltration of tissues may be undesirable from a mechanical one, because the devitalizing effect of the trauma to the tissues will favor the development of infection. Nitrous oxid and oxygen give poor relaxation, hence are unsatisfactory for most abdominal procedures. Our preference for all operative procedures on the lower extremity, perineum, lower urinary tract and lower abdomen has been spinal anesthesia. We have used 50-150 milligrams of novocain, dissolved in 1 to 3 cubic centimeters of spinal fluid, depending on the height and duration of analgesia desired. Ephedrin has been used routinely as a pre-anesthetic medication. In the upper abdomen we have usually used local infiltration of the skin combined with nitrous oxid and oxygen. In the younger patient who is free from demonstrable cardiac disease, spinal anesthesia may occasionally be used here as well.

For operations about the head and neck, including thyroidectomy, local infiltration, nitrous oxid or a combination of both have been preferred.[12-21]

REPORT OF CASES

Case 1.—F. H., a girl, age eleven, had had a severe grade of diabetes for two years. Dietetic control had been imperfect. Twenty-four hours before admission to hospital she developed pain in the right lower quadrant of the abdomen, associated with nausea and vomiting. Insulin had been discontinued. On admission she was comatose. Body temperature was 101 degrees, respiration 30, pulse 35. The skin was dry. No cyanosis was observed. The breath reeked with the odor of acetone. The abdomen was soft, except in the right lower quadrant, where tenderness and rigidity were present. The urine contained albumen 4 plus, sugar 4 plus, acetone 4 plus, and diacetic acid 4 plus. The blood sugar was 440 milligram per cent, and the carbon dioxid combining power of the plasma 24 volume per cent. The blood count was: Hemoglobin, 97 per cent; red blood cells, 4,740,000; white blood cells, 23,350.

One and one-half hours later all spontaneous pain had left the abdomen, and no rigidity nor tenderness could be detected over McBurney's point. Her temperature had fallen to 98 degrees. After four hours her condition was greatly improved. The white blood count had fallen to 19,600. The urine contained sugar plus, acetone plus, diacetic acid 0. The blood sugar was 184 milligram per cent. Eighty units of insulin and 1,000 cubic centimeters of normal saline solution had been given. Recovery was uneventful. There has been no recurrence of the right lower quadrant pain to date.

* * *

Case 2.—C. M., woman fifty-seven years old, was known to have had diabetes for five years. For five months before admission she had suffered from recurrent attacks of "acid type" of pain in the epigastrium one hour after meals.

Vomiting had brought relief. This had increased in frequency recently. Normal acid values for gastric juice were obtained. No abdominal mass could be palpated. Blood counts and the blood chlorid were normal. Gastro-intestinal x-ray examination revealed a highly obstructing lesion at the pyloric end of the stomach. Laparotomy under gas-oxygen ether revealed a greatly enlarged stomach, with a thickened and edematous wall. There was a firm cicatrix involving the first portion of the duodenum and completely obliterating the lumen. Posterior gastro-enterostomy was done. Sections of an adjacent lymph node revealed no evidence of malignancy. The incision healed by first intention and the postoperative course was uneventful.

Repeated gastric lavage had kept the stomach empty for several days prior to operation. One hundred to one hundred and fifty grams of glucose had been given daily (as 5 per cent glucose in normal saline). To each intravenous injection five units of insulin had been added. No food or fluid was given by mouth the first twenty-four hours after operation, and only chipped ice the second. Two thousand to three thousand cubic centimeters of 5 per cent glucose in normal saline were given each of these days. Forty-five units of insulin were required the first postoperative day and eighty the second, in order to keep the blood-sugar level (taken at four-hour intervals) below 200 milligram per cent. On the third day, skim milk and water were tolerated by mouth, and subsequently the usual bland diet. The diabetes was controlled at discharge with a maintenance diet and ten units twice daily.

* * *

Case 3.—M. S., a woman, age fifty-one years, had been under treatment for diabetes mellitus for one year prior to surgical interference. She had been sugar-free on a diet of C. 407, P. 110, F. 103, calories 2,995, with insulin units 18-3-10 daily. Attacks of sharp pain in the right upper quadrant of the abdomen, radiating to the shoulder blade and associated with nausea and vomiting, had been frequent. She had never been jaundiced. Three attempts to elicit a gall-bladder shadow by oral administration of dye had failed. A normal icteric index and bromsulphthalein test had been obtained. Cholecystectomy was done under local and gas-oxygen anesthesia. A "white" gall bladder attached to the duodenum with adhesions was removed. The incision healed by first intention and the postoperative course was uneventful.

On the morning of the operation, the patient's usual insulin dose and breakfast were omitted. She received 1,000 cubic centimeters of 5 per cent glucose in normal saline solution plus 10 units of insulin before going to the operating room. On the first postoperative day, 45 units of insulin and 165 grams of glucose as 5 per cent glucose in normal saline were given. On the second day, 1,100 cubic centimeters of the bland fruit juice and water were tolerated by mouth; in addition she received 2,000 cubic centimeters of normal saline by hypodermoclysis. On this day 35 units of insulin were required. On the third postoperative day, 35 units of insulin and 3,250 cubic centimeters of fluids were given. On this day, also milk, bouillon, junket, and egg white were tolerated by mouth. At discharge from the hospital the diet was: C. 286, P. 104, F. 71, calories 2199. She was sugar-free with insulin 22-7-19 units.

* * *

Case 4.—E. G. A., woman, age fifty-six years, had had diabetes for twenty-two years. Diet had not been followed and insulin had been refused. She had had an infected "corn" on the right fifth toe for one year. Pus had drained from this lesion intermittently during that time. One week before admission the calf of the right leg had become swollen and painful and the skin red. At the same time a tender swollen mass had appeared in the left forearm. Heat had been applied to the forearm. Blisters had resulted over the volar surface and at the elbow. Thirst, appetite, and urination had increased perceptibly the week before admission.

On admission the entire left forearm was swollen, red, and tender. Many oval necrotic areas were present on this surface and one covered the elbow. The forearm was flexed 90 degrees on the upper arm. The patient could not close her fingers. The fifth toe and lateral surface of the right foot were bluish black. Pus exuded from the base of the fifth toe. The dorsum of this foot was edematous. A hard, tender mass was present in the bellies of the gastrocnemius muscle. No red streaks were noted, but enlarged, tender glands were found in the right groin. Body temperature on admission was 100.8 degrees. The urine contained sugar 4 plus, acetone 3 plus, and diacetic 2 plus. The blood sugar was 590 milligram per cent. The white blood cells were 14,650.

The patient was prepared for surgery in the usual fashion. Three days after admission a Callander amputation was performed under spinal anesthesia. The whole posterior aspect of the removed leg was found to be diffusely infiltrated with pus. Healing was uneventful.

Fifteen days after admission the lesion in the left forearm had become localized. Through and through drains were inserted after incision and evacuation of pus. Healing was uneventful. The patient was discharged from the hospital controlled on C. 167, P. 76, F. 82, calories 1,710, with 25 units of insulin twice daily.

CONCLUSIONS

Analysis of the chemical, physiological and mechanical problems presented by surgical treatment of the diabetic patient suggests certain conclusions:

1. The surgical diabetic patient is primarily a medical problem.

2. The surgeon must be "diabetes minded," and willing to work in close coöperation with the internist.

3. A thorough understanding of acidosis and peripheral circulatory collapse is essential to successful treatment.

4. The choice of anesthetic should be individualized.

5. Diabetes in the surgical patient should not greatly influence the operative risk.

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DISCUSSION

Emile Holman, M.D. (Stanford University Medical School, San Francisco).—Only complete agreement with the authors is possible in their able treatment of the need of fluids, and more fluids, in the care of the diabetic. Too often but a minimum attention is paid to the importance of maintaining in all conditions of illness or operative care an adequate fluid supply to insure a proper balance between intake and output. It is only recently that total blood volume has been accorded the importance it deserves, particularly in the period of water deprivation that precedes any operation to be performed under a general anesthesia. Patients are denied replenishment of body fluid at the time of greatest need. Accordingly, it cannot be too strongly emphasized that before any major operation the deprivation of water by mouth should be counteracted by either subcutaneous or intravenous infusions—given *before* operation as well as *after* operation.

The site of amputation is determined by the extent of infection, the severity of arteriosclerosis, the degree of patency of arteries and, obviously, by the amount of demonstrable gangrene. Occasionally, in the presence of a partially gangrenous digit, largely the result of infection which has developed in spite of palpable dorsalis pedis and posterior tibial arteries, we have been content to control the diabetes, and later perform an amputation of the toe. Gangrene and infection of the foot occur on occasion in the presence of a very vigorously beating popliteal vessel. Amputation below the knee has been performed and good healing obtained. Mid-thigh amputations are obviously preferable in elderly patients, with extensive obliteration of the vascular tree.

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William C. Boeck, M.D. (1919 Wilshire Boulevard, Los Angeles).—This paper, recounting the experience of the authors in the medico-surgical treatment of diabetic patients requiring operation, illustrates most beautifully how excellent results are obtained by the coöperation of the internist and surgeon. These splendid results in this study were secured because both the internist and surgeon were familiar with the fundamental necessities of the preoperative, operative, and postoperative care of the diabetic patients, not only from the medical but from the surgical viewpoint as well. It follows, therefore, that while it is desirable for internists and surgeons to coöperate in the care of these diabetic surgical patients, yet the results will not be ideal if either one is lacking in the knowledge required of each. The internist should know the medico-dietetic management of diabetes in order that the diabetic state may be balanced and controlled, and that any disturbance in body chemistry may be completely corrected, or as nearly as possible. The surgeon, on the other hand, must also have this knowledge in part and, above all, should have had experience in diabetic surgery. This will enable him to make a wise selection of the type of anesthesia, operation, and with the internist he will see that the postoperative care is proper in order to avoid complications and possible death from coma.

Fortunately, most operations upon diabetic patients are elective, and only occasionally is an emergency operation necessary. Therefore, there is adequate time to control the glycosuria of the patient by diet and insulin if necessary. No patient should be submitted to operation unless his diabetes is well under control. If this is not done, and the operation is performed while there is marked glycosuria and a high blood sugar, acidosis and probably coma will ensue postoperatively, since operations like infections increase the severity of the diabetes.

It follows that diabetic patients who have been operated upon must be followed closely after operation and their glycosuria cleared up by adequate insulin dosage, along with the other items of postoperative care as given in this paper. I do not feel it is necessary, however, to do this by repeated blood-sugar determinations as practiced by the authors. On our own diabetic service we find it only necessary to have blood-sugar determinations at four to six hours postoperatively, perhaps again at ten or twelve hours, and then at intervals of twenty-four hours. We are able to ascertain the diabetic state by urinalysis for sugar alone, and prescribing insulin as necessary at intervals of one or two hours. In order to carry out such examinations, we employ indwelling catheters in our patients, and to date there have not been any urinary infections following such procedure.

I wish it were possible for all diabetic patients to have the coöperation of both internist and surgeon whenever surgery, such as was accorded the patients upon which this paper is based, is necessary. Too frequently the surgeon acts alone, and asks the dietitian for a "diabetic diet" with no prescription as to carbohydrate, protein and fat constitution. Insulin is given, but often not enough to control the glycosuria, or to clear up the acidosis before the operation is performed, with the results that the patient may never awaken, death occurring from diabetic coma. It is sad, indeed, to know such occurrences are still taking place in some of our hospitals, for it is no improvement over pre-insulin days. Too bad, perhaps, that the surgeon was not familiar with the book "Diabetic Surgery," written by McKittrick and Root. Would it be asking too much if the hospitals had, as a requirement, that all diabetic patients who are to be operated upon must have consultation from an internist trained in diabetic management, even as we make it mandatory that internists consult upon cases of therapeutic abortion? Certainly, the demand is equally as important from the standpoint of the patient, the hospital, and the physician in charge.

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James B. Graeser, M.D. (2940 Summit Street, Oakland).—Although general principles of procedure may be discussed in a paper of this type, it is impossible to summarize or present accumulated experience, except in its broader aspects. As stressed by the authors, success in this particular field is dependent upon the combined effort of the internist experienced in handling diabetes under surgical conditions and the surgeon who is "diabetically minded." In elective operations a severe diabetic may be prepared for operation and controlled in the postoperative period with but little disturbance. The emergency operation in poorly controlled cases, on the other hand, presents a hazard greatly increased by the diabetic factor.

The authors' discussion of the postoperative care of laparotomies presents a model procedure.

MEDICINE AND NATIONAL POLICY*

By Morris Fishbein, M.D.
Chicago, Illinois

SINCE the earliest times the care of the public health has been recognized as of the greatest importance in the maintenance of any nation. As long ago as 1875, Dr. Henry Bowditch suggested that the American Medical Association support the appointment of a Minister of Health in the cabinet, and this was adopted by the House of Delegates in 1876. Today it is recognized that our government—federal, state, and local—is already intimately concerned in matters of health. Of the two million beds available for medical care, almost a

* A digest of the address given at the annual meeting of the Los Angeles County Medical Association on December 2, 1937, by the editor of *The Journal of the American Medical Association*. From the *Bulletin* of the Los Angeles County Medical Association.

million are in government-controlled institutions. Our federal departments have many medical functions such as the United States Public Health Service in the Treasury Department, the Food and Drugs Administration under Agriculture, Maternal and Child Welfare in the Labor Department, the care of the Indians and institutions for the insane in the Interior Department, Coast Guard in the Department of Commerce, and many other functions scattered under some of the special commissions. Yet today the vast majority of the care of the people of the United States in illness rests on the practitioners of medicine, a burden which they have voluntarily assumed and one which they do not propose to relinquish until they are satisfied that some other system will give better medical service to more and more people.

FOREIGN STATE-CONTROLLED SYSTEMS OF MEDICAL PRACTICE

In the organization of many foreign nations state-controlled systems of medical practice have been introduced to meet conditions which prevailed among their peoples. There is no good evidence that any one of these systems is yet recognized as an answer to the problem of adequate medical service for all of the people. The most that can be said for any of them is that it is an improvement on what those people had before. Today under our system of medical care we have the lowest rates for death, for infant mortality and for most of the infectious diseases that prevail anywhere in the world. Is there any good evidence that a radical change in our plan of medical care would bring about still further advancement? Actually the evidence seems to indicate that any fundamental revolution would depreciate the quality of medical care, inhibit initiative, and at the same time vastly increase the costs of the service rendered.

EVOLUTION OF MEDICAL PRACTICE IN AMERICA

Our system of medical care is a logical evolution of personal medical practice to meet every need as it has arisen—a process of evolution which still goes on, adapting itself smoothly to the needs of the new mechanized civilization. For every new problem organized medicine has developed its advisory councils, and these have consistently sought for higher standards and a wider application of the best available medical care. The Council on Medical Education and Hospitals has done more to raise the standards of medical education and hospital service than any governmental agency has accomplished or could accomplish. It accomplishes more by voluntary action with high ideals that could be achieved by any federal agency slowly unwinding the red tape of governmental inspection, and forcing action by the labored processes of legal procedure. Education and voluntary action in the field of health have invariably brought about great reforms with more facility than have been achieved by the pressure of confused, hasty and unscientific legislation.

THE FERMENT OF 1927: WHAT IT HAS GIVEN US

Since 1927 a ferment has been agitating the medical scene. It is the new concept of social service and the apotheosis of the so-called underprivileged. It is a social philosophy which places the needs of four or five million indigents, many of them trained to indigency by superlative coddling, above the health and welfare of forty million workers and their families. The campaign has been waged with abuse and vilification of the medical profession, with blandishments and appeals to cupidity, with slogans and with threats. We have heard that "everyone is entitled to the best of medical care for a price that he can afford to pay," an ideal never yet realized in any nation or in any community in this world. We have been told that the "doctors must develop a plan or the Government will develop one for them." In response the physicians have developed hundred of plans now being tried in many communities, knowing that there is no single formula or ritual that will answer for every community any more than there is a panacea for every syndrome or complication of symptoms.

SOME "FOUNDATION PROPONENTS" OF COMPULSION HEALTH INSURANCE

The Milbank Foundation promoted compulsory sickness insurance, spending many hundreds of thousands of dollars in its promotion, and it has departed from such propaganda as one of its functions. The Rosenwald Foundation has spent equally for at least a decade in promoting hospital insurance, and today less than one per cent of our population has chosen to avail itself of such insurance and the Rosenwald Foundation has closed up its department of medical service. Mr. E. A. Filene urged a half-dozen different panaceas through the Twentieth Century Fund, and the latest activity of that group has been the development of coöperatives for medical care among employees of the Home Owners' Loan Corporation and among employees of the Federal Farm Loan Banks, with the concept that a few physicians employed full time can give adequate medical care to many thousands of people on a contract basis. No one has ever demonstrated that any such a system of medical care even approximates in quality the kind of medical service that is available to the majority of workers in the United States with even less income than is given to these employees of the Government.

AMERICAN FOUNDATION STUDIES IN GOVERNMENT

Now come the principles and proposals emanating from the studies of the American Foundation Studies in Government. Behind these principles and the signatures of the 430 physicians who signed them is a record of political manipulation which should be better known to the medical profession and to the people. This manifesto has been heralded as a "revolt" in the American Medical Association in behalf of state medicine. Yet in a

period of six months there were only 430 signitures and already great numbers of the signers have withdrawn their names. Today we know that the circulation of this manifesto was planned and designed to impress the executive and legislative branches of our federal government with the view that the American Medical Association is disorganized, nor representative of medical thought throughout the nation, and opposed to the best interests of the people. Who may profit from such evidence of disorganization? Is there any proof that self-appointed Committees of Physicians are any better able to represent the opinion of the American medical profession than the democratically chosen House of Delegates of the American Medical Association? The representatives of the 106,000 physicians who constitute the membership, the largest in the history of the Association, actually 80 per cent of the reputable practicing physicians of our country, have declared themselves opposed to any fundamental change or revolution in the development, distribution or payment for medical service. They await evidence from some of the many plans now undergoing experimentation in various places, that a new technique is desirable and safe for the people. That is the scientific method.

MINISTER OF HEALTH IN THE PRESIDENT'S CABINET

The impression has been circulated that the American Medical Association opposes a Minister of Health in the Cabinet. This is absolutely untrue, and represents again the manner in which truth is manipulated to place the medical profession in an unfavorable light. In reorganization of our federal government affairs at least three proposals have been made relative to the place that should be occupied by medicine and the care of the public health. What medicine fears is the possibility of a single ministry to be concerned with the care of the indigent, unemployment, social service, education and public health. Here there is the possibility a single Minister of Indigency may be made superior to health or education. Out of such an establishment will come inevitably worse confusion and less efficiency than we have ever had in the past.

SCIENTIFIC PLANNING NEEDED

Obviously what is needed now is not a *plan*, but *scientific planning*. At its annual session in June, 1937, the American Medical Association reaffirmed its willingness to do its utmost today as it has in the past, to provide adequate medical service to those unable to pay either in whole or in part. It has urged that in every county the county medical society take the leadership in calling into coöperation health departments, community chests, and social service organizations, to ascertain the needs in that county and to work out suitable provisions for meeting those needs. In June, 1937, the American Medical Association officially reaffirmed its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigations together with any facilities of the Association. Thus far no call has come from any governmental or other qualified agency for the coöperation of the American Medical Association in studying the need of all or of any groups of people for medical service, or to determine to what extent any considerable proportion of our public are suffering from lack of medical care. The offer still stands as evidence of the willingness of the American Medical Association to aid in finding solutions for the problems that now prevail.

WORK OF COUNTY MEDICAL SOCIETIES

In many places throughout the United States today county medical societies already assume fully the burden of medical care for the indigent. In some places, under the leadership of county medical societies, all agencies concerned with the care of the sick and with preventive medicine, are working on plans to extend such care and at the same time to avoid duplication, inhibit waste, and prevent neglect. The Social Security Board, charged with the handling of unemployment and old age insurance, is making extensive studies of sickness and its care, although not yet has there been any report from that body as to the needs of the people or any recommendation as to how these needs shall be met. If the answer is to be sickness insurance, as it has been intimated the Dodd report would have recommended in California, let it be remembered that under such a system the burden falls wholly, after all, upon the worker. He pays up to 3 per cent of his wages, the employer contributes an additional sum which is then added to the costs of goods that the worker buys, and finally the Government contributes a portion out of the taxes that the worker pays. The end-result is a bureaucracy with two new government employees for every physician who gives medical service, and a system of red tape which diminishes the amount and quality of service that the physician can give. And when the bills become too great the government makes it even by diminishing the amount of money paid to the doctor for his service, or by recommending that the patients have less attention and less medicine for the illnesses covered by the system.

AMERICAN MEDICINE TODAY

American medicine, now superbly organized on a democratic basis, speaking with the voices of more than one hundred thousand physicians, promises again to do its utmost in coöperating with all of the other agencies now available to supply a high quality of medical service for all of the people. In doing so, however, it must conserve those features of medical practice which time and training and experience have shown to be absolutely essential to a high quality of medical care. The best results will never be achieved by a revolution in the organization and administration of medical service. They must come by a steady, persistent evolution.

535 North Dearborn Street.

CALIFORNIA VENEREAL DISEASE CONTROL PROGRAM *

By Malcolm H. Merrill, M.D.
San Francisco

IT was in 1492 that syphilis was introduced into Europe. This disease raged entirely unchecked for over four hundred years. It was 1837 before it was finally demonstrated that syphilis and gonorrhea were two different diseases. In 1879, the minute germ which causes gonorrhea was discovered. The pale, thin spiral-shaped germ which causes syphilis was discovered in 1905 by a young German scientist by the name of Schaudinn. The blood test used in the diagnosis of syphilis was devised in 1907, and salvarsan, the drug which has proved so highly effective in the treatment of syphilis, was finally prepared in 1910. It was called 606 because 605 preparations were prepared and tried before the effective drug was found. We now have compounds containing arsenic that are closely related to salvarsan and are less toxic and almost equally as effective. In 1922, it was discovered that bismuth compounds were also highly effective in the treatment of this disease. During the years since then extensive investigations have shown the amount and duration of treatment necessary.

CAUSES KNOWN

We have known for twenty-five years the cause of these diseases; the mode of transmission or how they are spread; how they can be prevented, and in the case of syphilis we have had highly effective methods of treatment. For years we have had all the scientific information about these diseases that is necessary for their eradication. This is particularly true with regard to syphilis. Yet, what have we accomplished? While the application of our knowledge has worked wonders in the control of smallpox, diphtheria, typhoid fever and tuberculosis, the venereal diseases have continued to run rampant. These diseases, and particularly gonorrhea, are almost as prevalent today as they were at the turn of the century.

'Way back in 1895 there were instances of agitation for control measures by occasional physicians. But these received little attention. A pamphlet was prepared by the United States Public Health Service in 1908 in which these diseases were very conservatively discussed, but the pamphlet was returned, disapproved by the Secretary of the Treasury, with the following comment: "The matter contained in this bulletin is not in keeping with the dignity of the fiscal department of government."

FIRST EFFORTS IN CALIFORNIA

Feeble efforts at control were begun in 1912. In California, reporting was begun and a modest educational campaign was launched. However, little headway was made anywhere until the war. Then a nation-wide control movement was undertaken. Definite programs were developed in forty-six states under federal direction. The Bureau of Venereal Diseases was established in California in 1917 and then followed three years in which there was an extensive control campaign. A number of clinics were established. Wide publicity was given the movement and the incidence of the venereal diseases was undoubtedly held down as a result of this work. At that time, however, newspapers and popular periodicals were extremely hesitant in their discussion of the problem.

POST-WAR PERIOD

At the end of the war all federal funds were withdrawn and coördinated campaign collapsed. As occurred in other states, in 1920 the California State Department of Public Health was forced, because of lack of funds, to abandon its Bureau of Venereal Diseases. Despite this collapse of coördinated activity there remained throughout California a number of islands of activity in the form of programs within local health departments, for example, in San Joaquin County, San Diego, Long Beach, Los Angeles, and San Francisco. The activity of these local departments has continued since that time. Beginning about 1926, scientific interest in these diseases began to be intensified, and during the last ten years, under the direction of the United States Public Health Service, a tremendous amount of extremely valuable data has been collected. With the recent advent of Dr. Thomas Parran as Surgeon-General of the United States Public Health Service, a nation-wide campaign was begun. Fortunately, some funds were provided through the Social Security Act to make the movement possible. Of the eight million dollars allotted to the United States Public Health Service, approximately one million dollars has been allotted to states for the control of venereal diseases. Taking advantage of this, California reëstablished the Bureau of Venereal Diseases in February of this year and a state-wide control program was initiated.

APPROPRIATION BY THE 1935 CALIFORNIA LEGISLATURE

The recent session of our State Legislature adopted legislation and, through appropriation, added to the funds for the carrying on of the program. With the funds available, an active program for California is assured. There is a nation-wide program now under way. Almost every state in the Union is developing a special department for venereal disease control, and the movement is going rapidly forward. The United States Public Health Service is acting primarily in an advisory capacity to coördinate the national program.

In California the State Department of Public Health is similarly acting in an advisory and coördinating capacity to the local health departments. The aim is to assist in the development of effective programs within these local departments.

PREVALENCE OF THE DISEASES

How prevalent are these diseases? During the month of September, 1937, 1,897 cases of gonorrhea and 1,825 cases of syphilis were reported to

* From the Bureau of Venereal Diseases, California State Department of Public Health. Excerpts from an address presented at Veterans Memorial Auditorium, San Francisco, October 21, 1937.

the California State Department of Public Health. If this rate persists throughout the year, it would mean approximately 45,000 cases per year. About 75 per cent of new infections occur before the age of thirty years. From the results of surveys we have run in recent months we are now convinced that not more than 50 per cent of the cases are actually being reported. These same surveys have also indicated to us that there are constantly under treatment approximately 40,000 cases in California, or between four and six cases for 1,000 of population.

MONEY COST OF SYPHILIS AND GONORRHEA

It is impossible to estimate the cost of these diseases to the citizenry of California. It costs over one-half million dollars per year to maintain in our state hospitals patients afflicted with central nervous system syphilis. The cost of treatment of the 40,000 cases that are constantly receiving medical care cannot be estimated, but must be several millions of dollars annually. The loss incident to physical incapacitation and loss of time at work of this large army of people likewise cannot be estimated.

PAST EXPENDITURES

We have been interested in determining how much money is being expended to prevent these diseases. Before the advent of the present campaign the total expenditure by local health departments was approximately $200,000 per year or 3½ cents per capita for the people of the State. With the money now available this has been increased to about 5½ cents per capita. Local health departments that have fair programs under way are expending about 10 cents per capita. Most of this money heretofore has been used in clinic and laboratory service. Little effort has been made to find sources of infection or contacts and get these people under treatment. The Department was interested in knowing where their cases were receiving treatment. It was found that about 75 per cent are under the care of private physicians. Twenty-five per cent were being treated in free clinics. There are approximately eighty such clinics scattered throughout the State where treatments are being given. In July of this year 9,813 patients were under treatment in these eighty clinics.

PUBLIC HEALTH SUPERVISION OF PATIENTS UNDER TREATMENT

It has been found that there is a gross deficiency in the public health control of the 75 per cent of the cases that are under the care of private physicians. Only about 10 per cent of these patients have been reported to the health department, and there has been no coördinated effort to find the sources of infection or contacts in these cases. A large proportion of all patients have been found to lapse from treatment before treatment is completed. Many persons never get under the care of a physician at all, such patients placing themselves in the hands of quacks or attempting self-treatment.

EDUCATIONAL CAMPAIGN NEEDED

In the campaign against tuberculosis, smallpox, and diphtheria, education has been found to be the most important single factor. We have no reason to believe that an exception should be made in this respect in reference to venereal diseases. Consequently, an intensive effort is to be made to inform the public concerning these diseases. The Department wants the public to know the nature of these infections, their cause, how they are spread, and how they are treated. Literature is being prepared for wide distribution. Lectures, motion pictures, newspapers, and posters will be used. All this will help to insure close coöperation between lay organizations, physicians, and public health agencies. A fundamental phase of the educational program is the introduction of adequate instruction in our elementary and secondary schools and colleges. Such courses must be designed to give information about public health in general with venereal diseases being discussed along with other infectious diseases. This educational program is designed for two primary purposes. First, to prevent new infections from occurring; and second, to convince the public at large of the necessity of early medical care once infection occurs.

TREATMENT MUST BE AVAILABLE FOR EVERY PATIENT

Next to the educational program perhaps the most important factor is to assure that treatment is available for every patient. Proper treatment is fundamental in the control of these diseases so that infection may not be spread from the infected to normal individuals. In an effort to assure that treatment is available, clinic service will have to be made more adequate. Standards of treatment and the facilities in the eighty or so clinics are being improved, and the clinic periods are being extended. Free drugs are being distributed to private physicians in an effort to assist them in the care of indigent and part-pay patients. The treatment of syphilis is so effective that if we could bring all cases under treatment at the same time and continue treatment for the prescribed eighteen months to two years our problem would be practically solved.

ELEMENTS IN A STATE PROGRAM

In order to get as many patients as possible under treatment, extensive epidemiological work is necessary. Public health nurses will be assigned to various health departments throughout the State to assist the health officers in case finding and assuring continuation of treatment. You will be interested to know that about 80 per cent of all cases of syphilis lapse from treatment prematurely. This epidemiological work has tremendous possibilities, but also involves intricate problems in human relationships. Tact, care, and a humanitarian outlook are going to be necessary. The vast majority of patients will coöperate if they are made to feel that these are infectious diseases and that our sole interest is in the protection of themselves against late complications of the disease and the protection of their associates against infection. The Department is endeavoring to eliminate any element of social stigma or punishment in this approach. We are adopting the axiom, "What would we do if this were a case of smallpox?" and attempting to ap-

proach the problem in the same wholesome, scientific manner. Legal measures will be necessary, but we feel they will be required in rare cases only. We must have the legal power to enforce quarantine and isolation upon uncoöperative patients who are a menace to the public, especially those engaged in illegal activities. This power will rarely need to be exercised if the patient is made to understand our objectives and the reasons for our insistence upon their receiving treatment and abiding by regulations set down. Coercion must be our last resort, but it must be employed if the protection of the public is involved.

The program for the eradication of the venereal diseases is to be coördinated with other public health activities. This is but one phase of public health work. Heretofore it has been given grossly inadequate attention. In the field of infectious disease control it is the most urgent problem at the present time. Just as from time to time emphasis has been directed to typhoid, diphtheria, tuberculosis and other diseases, it is now being directed to venereal diseases.

CLINIC SERVICE

Next let us consider the problem of clinic service. About 25 per cent of those with venereal disease either cannot or will not pay for medical care. This group must be cared for in free clinics, or where no clinics are available, under some other arrangement.

It is fundamentally a health department function to see that treatment is provided for venereal disease patients. If free clinics meeting adequate standards are operated by county hospital or other agencies, there is no reason for health departments to duplicate this service. Health departments, however, are responsible for seeing that standards are maintained and that the epidemiological work is done in these clinics. As noted before, there are now about eighty clinics reporting to the state department. Some additional clinics in certain rural centers will have to be established and activities of many present clinics extended.

There are a few fundamental requirements that all clinics should meet. These were set forth in a report to clinics some time ago, and need not be given in detail here. The admission requirements, however, are worthy of reëmphasis. The following classes of patients should be admitted:

1. Any patient for initial diagnosis and emergency treatment if found infected.

2. Any patient referred by a private physician for consultation or special tests.

3. Any patient honestly unable to pay a private physician for treatment.

Residence requirements must be completely abolished. There are still a few clinics in the State that refuse to admit patients who cannot fulfill the local residence requirements. The fact that a patient is not a resident of three years' standing does not eliminate that patient as a public health menace.

We are prepared to assist clinics in the following ways:

1. We have prepared clinic record forms for issuance to any clinics desiring to use them.

2. We are rapidly working out plans for further assistance to clinics in the form of drugs, personnel or equipment, depending upon the need and the manifest desire to coöperate.

3. Clinics will be visited periodically and every effort made to assist them in the solution of their problems, medical as well as administrative.

The venereal disease control program of the local health department really centers about the clinic. Personnel from the health department should be in attendance at every clinic period to consult with the patients, check on missed treatments, to investigate contacts of clinic patients and attempt to find sources of infection. Health departments cannot reasonably expect county hospitals or other treatment agencies to relieve them of this work. We would recommend the establishment of a venereal disease registry in every health department. Specially trained nursing personnel will have to be added to a number of departments. We are working on plans for specialized training for this personnel.

INDIGENTS IN RURAL DISTRICTS

The provision of treatment for indigent patients in rural districts is a special problem. As soon as possible we hope to arrange to subsidize local physicians in these outlying districts for the care of these patients. Such cases will be investigated by personnel either from the local health department or from our own staff.

LABORATORY SERVICE

Adequate laboratory service is necessary. As a result of the wide publicity the load on private as well as public laboratories all over the State has markedly increased. Laboratory service for diagnosis must be available for all and, as with clinic service, free tests must be available for indigent patients. This will necessitate the extension of activity on the part of some local health departments.

A system of checking on state laboratories on a nation-wide basis has recently been developed by the United States Public Health Service. We plan to carry out the same general system on a state basis in California. The State Laboratory personnel is being sufficiently expanded to take care of this work.

THE HOPE OF THE PRESENT CAMPAIGN

The program in 1917 collapsed because it was built from the top down. It was more or less pushed onto the people by governmental agencies. The present program already has the support of the great mass of the people upon whose support the success of the movement essentially depends. It has the hearty endorsement and coöperation of the press, which was woefully lacking in 1917. With continued support progress in the control of these diseases can be effected.

The physician-health department relationship is not a one-sided affair. Health departments can be of definite assistance to physicians in the care of their venereal disease cases. We can assist them in keeping these cases under treatment. We can return their cases to treatment if lapses occur. We can render direct assistance to the physician by pro-

viding drugs. In return the physician can assist us by coöperating in the epidemiological work.

We believe that if we attack this phase of the problem tactfully, vigorously, and with sincerity of purpose, the physicians will rally to our support.

SUMMARY

1. Efforts are to be made to enlist the coöperation of physicians in reporting and in epidemiological investigation.
2. We are to endeavor to insure adequate clinic service by coöperation with and assistance to clinics. We may need to establish some new clinics.
3. Provisions are to be made for the care of indigent patients in rural districts.
4. Serodiagnostic laboratory service is to be standardized and, where necessary, extended.
5. Epidemiological work is to be markedly extended.
6. Free drugs for the treatment of syphilis are to be dispensed to physicians for the treatment of free and part-pay patients.
7. There is to be an active educational program for both the medical and nonmedical public.
8. The responsibility of local municipalities and health departments for the program in their districts is to be maintained.

A venereal disease control program is here to stay. With energetic control measures, continuously applied, we can expect results.

State Office Building,
McAllister and Larkin Streets.

THE LURE OF MEDICAL HISTORY†

WILLIAM WATT KERR

III*

By Herbert C. Moffitt, M.D.
San Francisco

THERE are few cities of the world so beautifully situated, few so interesting from wealth of history and tradition as Edinburgh—"Auld Reekie," or the "Athens of the North." It was there, in Newington Parish, July 27, 1857, that William Watt Kerr was born. The first well-known Ker, either of Newbattle or Temple parish, a few miles south of Edinburgh, was given only one "r" in his name, but during the next generation the other "r" was added, undoubtedly to afford the proper Scottish burr that *we* knew in Ker-r. He was a branch of the family known as the Kers of Ferniehirst, with the Marquis of Lothian as chief. James Kerr the second settled in Liberton, on the outskirts of town, about 1730, married Janet Johnstone, and had twin boys and a daughter. John, one of the twins, married Janet Rait and they had nine children; he married again, Anne Bethune Taylor, and they had two sons—Alan, who died in infancy, and Andrew, the father of Doctor Kerr. Andrew Kerr, born May 13, 1814, in the parish of Liberton, was a noted architect and an antiquarian of renown. By competitive examinations he became a member of Her Majesty's Board of Public Works, in charge of all public buildings of Scotland. The postoffice of Edinburgh, the fountain in front of Holyrood Palace, are mentioned as his work. He was a Fellow of the Royal Antiquarian Society and, on retiring from the Board of Works at sixty, devoted himself to antiquarian architecture, restoring Baron's Hall at Dawn Castle for the Earl of Moray, and Rosslyn Chapel for the Fourth Earl of Rosslyn, and was actively in demand for similar restorations until his death at the age of seventy-three. He was a burgess of Edinburgh, a member of the Merchant Company, one of the Holyrood constables, well liked, well known as a good talker and raconteur—gifts which he transmitted to his sons. On December 18, 1840, he married Grace Watt, the daughter of James and Janet Watt, by whom he had nine children: John, Janet, James, Andrew, David, Annie, Euphemia, William, and Robert. By all accounts Janet MacAlpine, the doctor's grandmother, was a remarkable, forceful, intellectual matriarch, who knew what she wanted, and usually got it. The laird had proposed for her hand, and had strong backing from her parents. The parents argued, Janet objected, the laird agreed to wait, but a friendly minister was found; a sister snooping—as sisters will—discovered a marriage certificate in the names of James and Janet, and the fat was in the fire. The marriage was perfectly legal and could not be undone; but the culprits were brought before the Kirk Session, a strict and sour assemblage in those days. They were both children of elders of the Kirk, iniquity in such high places must be sternly dealt with, and a double fine was levied. But "Na, Na," said the bridegroom, "come awa, Jenny," and left the elders to rattle the few coins of a single fine.

Doctor Kerr's mother died on April 17, 1900, and is buried in Grange Cathedral with her husband. The memory of a daughter, Phemie, then seventy-one, is given of her in a letter written to James Kerr in September, 1926: "To describe her would be just impossible. She certainly, for more than four score years, had wrought for others, soothed the hurt of tears, rocked children's cradles, eased the fever's smart, dropped balm of love in many an aching heart, and father never would have been the man he was had she not been his life's companion."

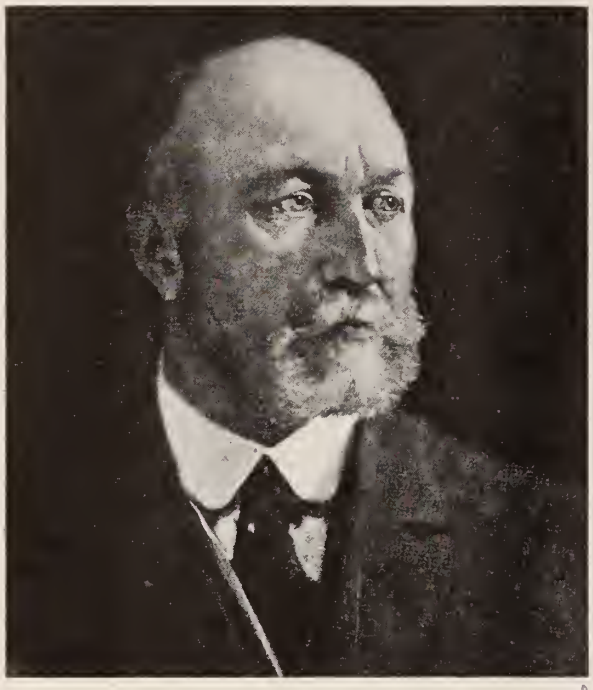
UNDERGRADUATE DAYS

From the Royal High School William Watt Kerr entered the University of Edinburgh, was graduated in April, 1876, and passed his examinations in medicine in the spring of 1881, with the degrees A.M., M.B., C.M. We know that he played football at the University, but unfortunately little more. We know, however, that, in his time, interesting characters were to be seen strolling through the meadows near the Royal Infirmary, or climbing the hilly streets between the high-piled buildings of the town. John Stuart Blackie (whom we learn

† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

This is Paper III of the series. For other articles in the symposium, see California and Western Medicine, November, 1937, page 321; December, page 405.



WILLIAM WATT KERR, A.M., M.B., C.M.
1887–1889—Professor of Therapeutics
1889–1917—Clinical Professor of Medicine
University of California Medical School

of from "Christopher North"), the great teacher of Greek and the humanities, the prototype of the absent-minded professor, could be seen stalking about the city with his famous plaid over his shoulders. Passing the consulting rooms of a noted surgeon one day, he went in to have a sudden, pronounced limp investigated. It was found that he had been walking with one foot on the curb, the other in the gutter—hence the limp. Probably Sir William Turner, professor of anatomy and noted anthropologist, was dissecting his famous high-powered seventy-foot whale in the quadrangle about this time, which got him into decidedly bad odor with the townfolk. And Doctor Kerr may have attended the lectures of Alexander Crum Brown, professor of chemistry and a great character and scholar—a series on the "Alphabet" which lasted through the year and never got beyond the letter "C." During these years Joseph Bell was attracting crowds of students to his extramural lectures, wholly unaware that he was sitting for the portrait of the famous Sherlock Holmes, for Conan Doyle was then at the University, awaiting graduation as M. B. in 1881, and M. D. in 1885. Stirring events were shaping history at the Royal Infirmary during Doctor Kerr's time. Fifteen hundred students were attending lectures in medicine. In the surgical building, Lister, who returned to Edinburgh in 1869, was demonstrating his epochal discoveries, his meticulous care of antisepsis and of dressings, until he went to London in 1877. The new buildings of the University were completed in 1879, and "Farewell to the old Infirmary!" was sung with "Auld Lang Syne" by the resident staff in October of that year. Perhaps an inspiration for Doctor McNutt's poem of farewell to the old Toland school just twenty years later!

LURE OF CALIFORNIA

Doctor Kerr left Edinburgh in 1881 with inheritance of health, pride of family, *noblesse oblige,* and the highest principles; with traditions of a great University behind him, with the inspiring new medical teaching at his command. Fortunately for us, his uncles, William and Robert Watt, had been in California for years and had risen to be chief owners of the famous old Eureka mine in Grass Valley, and this affected the doctor's decision to come to the Pacific Coast. His brother, James Watt Kerr, eleven years older, a noted mining engineer, had arrived in 1867 to take charge of the mine, had moved to San Francisco in 1874, when the Colmans assumed control, and had started manufacturing mining machinery. Mr. Kerr was an interesting man whom many of us knew—impressive, forceful, uncompromising in his strict interpretation of business integrity. His strong stand in several big San Francisco strikes is well remembered. For several years Doctor Kerr made his home with his brother on Octavia Street, and it was there that he met Miss Rowena Boobar, whom he married in 1886. All know the happiness that each succeeding year brought in greater measure to both. Mrs. Kerr lived but to anticipate the doctor's needs and wishes; when she saw him anxious, tired, not in his usual harmony with the world, she would suggest a dinner with his old cronies—chief among them, Swan, Lewitt, Wadsworth, and von Hoffman. Straightway his face would beam and planning of the menu began. Mrs. Kerr died of heart disease on December 23, 1934.

EARLY DAYS IN SAN FRANCISCO

With the triumphs of Listerism fresh in mind, Doctor Kerr at first intended to do mainly surgery. He became associated, however, with Dr. James Simpson, a relative by marriage of his brother, and gradually took over both the office and outside medical practice. Doctor Simpson had prospered in various mining towns in California, and had moved to San Francisco in 1872, where he continued his success. He was professor of materia medica and therapeutics for four years at Toland from 1879 to 1883. Henry Harris has characterized him as "a rare, sound uplifter, devoid of killjoy, a sophisticated and recurring sampler of straight or mixed beverages." This association, and his growing reputation as an authority on diseases of the chest, determined once and for all Doctor Kerr's future bent, and he gave away his surgical instruments. But for many years he practiced obstetrics, which had been so ably taught in Edinburgh by Sir Alex Russell Simpson, of whom he often spoke. He always liked the specialty, was extremely good at it, and only gave it up when warnings of his circulatory limitations no longer could be ignored. He was a sworn foe of the abominable "formulas" so often forced down infants' throats, and was always seeking substantial if not highly moral wet nurses. Those of us who remember Jimmy, his driver for many years, who sat in the hall during office hours after the doctor moved from 522 and later 600 Sutter Street, will recall the arguments with Nellie, who ushered in

the patients, as to shunting of portly ladies into the private or the supply departments.

INTEREST IN ORGANIZED MEDICINE

Despite his youth, practice grew rapidly, and he was active in many other ways. As early as 1882 his name appears as a member of the State Medical Society in the published volume of transactions. During the next years he was a member and later chairman of the Board of Censors, a member of committees on public health, clinical medicine, microscopy, and in 1887 rendered a report as chairman of the Committee on the Practice of Medicine. It would be interesting, at some future date, to quote longer excerpts from this report, from his address as president of the State Society and from his various papers on the heart. In the report of 1887 he said: "Perhaps the most distinctive feature in medical thought at the present time is the tendency to adopt a local treatment instead of internal medication. What may be regarded as minor surgery is becoming more common among physicians, while under their advice new and graver operations are undertaken for which the skill of the specialist in this department is required. Indeed, so aggressive has surgery become that it is frequently impossible to decide to which department the cases belong, and it is absolutely necessary for the physician to understand the risks and responsibilities of each operation, since with him lies the responsibility of recommending it at an early stage or temporizing."

CHAIRS IN THE MEDICAL SCHOOL

Some time in 1885 and 1886 he is reported to have worked with Doctor James Blake on the pharmacology of cerium salts; and on June 12, 1886, the faculty of Cooper Medical College passed resolutions thanking him for a course of lectures on hygiene, which he had delivered during the winter semester of 1885. On December 27, 1886, he was appointed professor of therapeutics in the Medical School of the University of California, resigning January 8, 1889, to become professor of clinical medicine, a position he held until his death, April 26, 1917. Even while in charge of therapeutics he had been teaching medicine in the wards under Doctor Kane, whom he succeeded.

A BUSY LIFE

And now, until the earthquake and fire, followed tremendous years, though made up largely of horse-and-buggy days. He was increasingly in demand as a consultant, as well as a family physician. Visits before his eight o'clock lectures, fifteen to twenty more during the morning, still others after office hours, kept Jimmy and two teams circulating rapidly all over town. He was always particularly interested in diseases of the circulatory system, but covered the field of general medicine in his practice as in his lectures. He was a keen observer, a master of percussion, auscultation and palpation. Despite early contact with the model of Sherlock Holmes, he always warned against snap diagnoses. And yet, as Doctor von Adelung has recently written me, "Doctor Kerr possessed what is sometimes called the sixth sense in medicine, the diagnostic 'hunch,' which is not a hunch but wisdom acquired by long, close study and careful observation." He was much impressed with Jonathan Hutchinson's little book on "The Pedigree of Disease," which appeared in 1886. With him the proper order of procedure was careful examination, individualization, consideration of constitution, temperament and idiosyncrasies, and finally prescribing. As the conclusion of his report on medicine to the State Society in 1887, he wrote: "In the treatment of disease the physician should endeavor to have the normal and perverted physiological processes in each individual case as clearly before his mind as the surgeon has the arteries, veins, and nerves that he is to avoid in the performance of some operation." Again: "There is too much 'book' medicine at present, too great a tendency to regard the sick as something closely akin to a vessel containing certain noxious ingredients which are neutralized by the additions of certain antidotes; and too strong an inclination to look upon the patient as a machine out of repair, instead of a living being in whom vital and chemical changes are taking place that must more or less interfere with our remedies." In later years he used comparatively few drugs, but had faith in digitalis, arsenic iodids, bromids, and opium. It is interesting to glance through old files of Lengfeld's Pharmacy, kindly furnished by the managers of the Shumate stores, and to find his small, neatly written prescriptions, signed "Wm. Watt Kerr," calling for his old favorites, Murchisan's pills or codein with syrup of tolu. A lesson in prescribing promiscuously was taught him, he told Doctor Woolsey, by one of his early patients. He had been assiduous in attending a maiden lady, frequently changing medicines during six or eight months. Finally, he told her his services were no longer needed, as she had completely recovered. She spoke of the great value of the many remedies, and he felt duly complimented. She then raised the two pillows of her bed and underneath, marshalled in imposing rows, were the many bottles, all *unopened*. That one lesson was enough! He was a clinician of the Edinburgh school, broadening, advancing each year by reading, teaching and experience with all kinds of diseases, all types of men, yet always ready to make use of new methods, new instruments in diagnosis; always eager to test new remedies, to profit by surgical advances. He, as well as Doctor Hirschfelder, experimented with tuberculin at the County Hospital in 1891. The Widal reaction was tried in his wards soon after it was described in 1896. He encouraged Doctor Ryfkogel in his clinical laboratory work, and stood stalwartly behind him and the courageous Board of Health when attacked by governor, big business, and a group of subservient doctors during the plague scandal of 1900.

GEORGE WILLIAMS HOOPER FOUNDATION

From student days, Doctor Kerr was familiar with the publications of Gull and Ord on myxedema. He had no difficulty, therefore, in recognizing a typical picture of the disease in Mr. George Williams Hooper, who consulted him soon after

the appearance of Murray's report of four cases treated successfully by juice expressed from thyroid glands of sheep. Mr. Hooper changed marvelously for the better soon after starting treatment, and daily thereafter sent to the slaughterhouses for fresh sheep thyroids. Somewhat later Doctor Kerr took Mr. Hooper to Doctor Starr of Philadelphia, who concurred in the diagnosis and suggested a trial of desiccated thyroid, which had been introduced in tablet form by the Parke Davis Company in 1893, one year after publication of Murray's paper. It is interesting to note that Mr. Hooper took twenty grains daily for many months, later only five grains of the Burroughs Wellcome preparation, and that in his last years only one-fifth grain, as any larger dose promptly caused disagreeable symptoms. To Mr. Hooper's interest in scientific and experimental medicine, aroused by Doctor Kerr, kept active by Doctor Ebright, we owe the George Williams Hooper Foundation.

DOCTOR KERR'S PERSONALITY

In a recent address before the Edinburgh Royal Medical Society—the oldest association of medical students in Great Britain—Lord Horder used words that could well have been applied to Doctor Kerr: "For the doctor there can be no left or right; for him there is expert knowledge and a rooted adherence to truth and horse sense." Patients were drawn to Doctor Kerr by his stalwart presence and winning personality; they loved him for his gentleness and kindness, and had confidence in his knowledge, his stability, his voice, even the creaking of his shoes as he climbed the stairs to the sickroom. They knew instinctively that he was honest, straightforward, dependable. No doctor ever had more loyal followers.

HIS RÔLE IN THE MEDICAL SCHOOL OF THE UNIVERSITY

Who can speak adequately of his thirty years devoted to teaching in the University of California? His soul was in his work, his heart was given to his students. Turn back the pages of the old announcements to 1887: "Professor Kerr will direct the attention of the student to general medical diseases, exercise him in physical and differential diagnosis, and give him every opportunity of putting into practice the knowledge he has acquired from his didactic lectures." Moreover, there was to be "instruction in all these details which qualify the student to discharge his duty agreeably and efficiently in the sickroom." Lovely language, but certainly *not* that of Doctor Kerr. Whose *was* the mysterious voice that echoed through the old announcements? Three times a week, Tuesdays, Thursdays, Saturdays, the clock struck eight as he entered the amphitheater. The black skull cap was taken from his pocket, unfolded, and usually donned. Standing, walking about, in later years sitting in his chair, he spoke easily, simply, of the disease in question, or demonstrated its characteristic features in patients brought from his wards. There was no drama, there were no frills, but the students felt that what he said was *so*. He aimed to cover the whole field of medicine in the course of lectures to the third and fourth years. It is interesting to see from these lists of diseases considered during the year that syphilis, tuberculosis, exanthemata, and other infections were kept in integral part of the department of medicine—where they still belong. Typhoid, cerebrospinal fever, and thirty-one cases of malaria are recorded in one year at the hospital, and 3,641 visits to the old clinic on New Montgomery Street. Only one man of this 3,641—so different from now—could be called a pay patient, and he came because he swallowed a five-dollar gold piece. Thanks to our present beneficent government, this could not happen here.

THE OLD CITY AND COUNTY HOSPITAL OF SAN FRANCISCO

The old City and County Hospital was erected in 1873. It was a great old place, full of memories that did not all go up in the smoke of its destruction. The site was well chosen, and we can vouch for the salubrious, stimulating Mission climate, for in 1899 six guinea pigs were presented to Doctor Ebright, and by the time of transference to Ingleside, there were at least two thousand. After August, 1907, when a case of bubonic plague was found, no new cases were admitted, and on January 2, 1908, the 130 patients remaining were transferred to a building on the Alms House Tract. On March 10, 1908, a fire broke out in this old four-story wooden building—fortunately, about eight in the morning—and all inmates were saved. Patients were then housed in the Alms House Building No. 1, and on April 10, 1908, were moved to the stables of the Ingleside Race Track. In the summer of 1909 the first reinforced concrete building erected in the city was completed on the Alms House Tract; habitués of the track were transferred and remained there until May, 1915, when the magnificent new San Francisco Hospital was opened. Picture the old county wards!—thirty-two beds, covered with the faded checkered pink, only to be duplicated on old-time restaurant tables; *Nachtische,* commodes or storage vans of the old ladies crammed with old shoes, hair switches, and paper bags of goodies; the old women, *full* of complaints, which faded to whispers at Doctor Kerr's approach, for his heartiness never failed to win a smile from even the most obstreperous virago. Through these wards walked with him students and internes, whose later careers were shaped as much by his example as by his teaching. It was my good luck to be welcomed by him here in 1898, my misfortune, soon after, to have a so-called promotion transfer me to Parnassus Heights. Those of you fortunate enough to have been his internes will recall his kindness, his justness, his square-dealing with alcoholic and other peccadillos. Would that we had time to recount his stories, to tell of his clinical acumen and keen use of all his senses. Passing one day the open door of one of the rooms for contagious diseases he paused, sniffed, and asked what case was there. "A case on the P and S service, hemorrhagic measles," replied the interne. "Better tell them to quarantine for smallpox," said Doctor Kerr, and so the case proved to be. Then, as now, patients with undesirable infections, with

finances running low, were transferred to the county from other hospitals. Two well-spotted patients were sent over from St. Luke's as suspected typhus. Doctor Kerr pronounced them typhoid; the Widal reaction, done almost for the first time by Ryfkogel and Ebright, said likewise. Giannini, who had volunteered to take care of them, was firmly persuaded that they and he, *too,* had typhus; but the autopsy proved typhoid, and Giannini recovered.

HIS CONTRIBUTIONS TO MEDICAL LITERATURE

Though swamped with practice, meticulous in care of teaching and hospital service, Doctor Kerr found time for writing and medical society activities. A list of his papers was published by J. Homer Woolsey in CALIFORNIA AND WESTERN MEDICINE (Vol. 23, p. 607). Of the thirty-four articles, seventeen dealt with diseases of the circulatory system. These were always interesting to him, and soon after arriving in San Francisco he wrote a long paper on functions of the capillaries, and in January, 1889, he reported two cases of aneurysm treated by wiring and electrolysis in October and December, 1887. His papers on myocardial insufficiency, angina pectoris, angina sine dolore, on the value of arsenic, iodids, protiodid of mercury in chronic heart disease, on the danger of hot baths in arteriosclerosis, on the necessity of caution in giving nitrites in angina pectoris, are full of valuable observations and suggestions that are well worth reviewing today. He emphasized the value of hyperesthesia in distribution of the left intercostohumeral nerve as a precursor of angina pectoris, was in favor of abandoning the vague term "pseudo-angina," spoke often in aphorisms or maxims, such as "Football men take more risks on bones and neck, but sprinters and hurdlers more on heart." Early descriptions of eosinophilia in trichiniasis, of typhoid meningitis, and a timely lecture on plague, showed his interest in application of laboratory methods to clinical medicine.

MEDICAL SOCIETY ACTIVITIES

He was president of the San Francisco Medical Society (1893-1894); president of the Academy of Medicine; president of the State Medical Society in 1898-1899. Those knowing only the amenities of golf, teas, and ladies auxiliaries of our emasculated meetings, can scarcely understand the vigorous language, picture the strenuous doings of the doctors of the eighties or nineties. Old warriors can still hear the thunder of C. P. Buckley against oxytuberculin and the plague, the queer but vehement English of Charles G. Kuhlmann, "I will once more iterate and demonstrate that bacteriological investigations are of no value in elucidating the causes of disease." We still see the fiery MacMonagle, the suave Tait rising to compliment the speaker and to annihilate him by quotations from the French. Some of us thought the earth trembled on the morning of April 18, 1906; it was but the reverberation of forces that shook it during three days of a state medical meeting in April, 1898. Doctor Pedlar of Fresno, in welcoming the State Society, uttered most high-minded sentiments: "We, the great army of busy physicians, come together as a fraternal body, and it is our duty to foster a fraternal spirit." Next day Doctor Kerr was nominated for the presidency by W. L. Wills of Los Angeles, and Washington Ayer proposed the name of Doctor McNutt, who, it was rumored, had written touching letters to the country practitioners and rather packed the court. In seconding the nomination of Doctor Kerr, Doctor MacMonagle made use of certain expressions and evidently forgot to smile. He was encountered later on the floor and charged by Doctor Potter, who, advancing his topper like a shield with his left, wielded his umbrella like a saber with his right. It is not uninstructive to read an account of the election: "As the votes progressed, the excitement became intense, and not until the last vote was counted could the result be foreseen. When, however, the smoke cleared away and the chair announced the vote as Kerr 48, McNutt 47, pandemonium reigned supreme, and the chair announced the election of Doctor Kerr by one vote, thus overlooking members who were calling for a recount." In an editorial in the journal of the rival faction (Doctors McNutt, Potter, Winslow Anderson, and others) it is stated plainly that "Doctor Kerr was not present, and it is believed would not have countenanced the methods had he been there." "To understand Doctor MacMonagle's intense excitement we have only to say that twice he called Doctor Potter 'Doctor Plummer,' and to understand Doctor Potter's extreme forbearance we have only to say that he stood this without resentment." Ready fists but *toujours la politesse* in those days! Some of you may remember the rather dubious congratulations of Doctor McNutt to the Medical School on moving from Toland to the Parnassus site: "In its new quarters, undisturbed by the chirp of the cricket and the souffle of the pines, the student can study nature in all her naturalness, free from clinics and dispensaries."

OSLER'S "DOCTOR'S DISEASE"

There is a disease, insidiously, often silently, undermining in its early stages, that too often strikes down men of our profession in their prime. Osler has called it the doctor's disease. Recent statistics of H. L. Smith, from the Mayo Clinic, emphasize again that its incidence is four times greater in physicians than in laborers or farmers, twice greater than in bankers, ministers, or lawyers. It has recently taken a great friend and doctor from our ranks. Doctor Kerr was singularly free of minor ills, although he had heard "the lispings of the gout" and experienced an attack of renal colic. On October 3, 1904, he had been catapulted from his autocar to the pavement, with resultant injuries to head and left shoulder that incapacitated him for four months, but fortunately left no permanent damage. Then, about 1910, he would frequently have to pause in corridors or wards because of claudication of the left leg. Later came an annoying sense of cold about the precordium and, still later, typical angina on exertion. Attacks came with slighter cause and with increasing pain. They did not ruffle his calm equanimity. Cheerfully he

put his house in order, and Mrs. Kerr and he never faltered on their path of duty. He studied, with curious intentness, the varied manifestations of advancing vascular changes. He published, one of several similar papers, "Notes on Angina Pectoris" in the State Journal in 1915, and a remarkable account of experiments on himself in an article entitled "Danger of Hot Baths in Patients Suffering from Arteriosclerosis" in the State Journal of 1916. He was seen in January, 1916, with his physician three days after an attack of coronary thrombosis. Even then he could not be persuaded to give up the work, the teaching he loved so well. Outwardly there was little change; but the year went by with increasing effort, and in March of 1917 he gave his last lecture, which has been dramatically described by one of the men present. Students waiting in the corridor saw him walk slowly from his car. Seating himself in the amphitheater, he paused longer than the customary time, glanced over the rows before him, and said, slowly: "We shall speak today of angina pectoris. Not of the pathology, which is familiar to you all, nor of the slighter pains which grip the chest and spread to arms—right as well as left—but of sensations that can less well be put in words. There comes a moment when the heart seems all too small to overcome the great pressure gathering in the chest. A massive column of blood seems surging upward and to the left and can find no outlet in passages that feel too rigid. And, rising from the chest, a constricting force grasps the throat and squeezes upward to the angles of the jaw." Students who heard him have never forgotten the hour—they saw him then for the last time. Soon after two o'clock on the afternoon of April 26, 1917, his nephew, Andrew Kerr, was seated in his waiting room in the Galen Building. C. C. Moore, an old friend and patient of the doctor, had just entered the consulting room, when he rushed back crying, "Something has happened to the doctor!" Doctor Kerr had risen from the desk to greet him, but had sunk back silently into his chair. When several of us got there a few minutes later, he had been laid upon a couch, on his face no sign of suffering. Doctor Kerr was dead.

A GREAT TEACHER, A GREAT PHYSICIAN, A GREAT MAN

His portrait and photographs speak eloquently of the Doctor Kerr we knew. We see there strength, honesty, kindliness, dignity. No wonder he was honored, revered, and loved. To his students he was always "Daddy Kerr." Deeply religious, but without parade, he was a good citizen, a loyal friend, a lover of his native and his adopted lands. Grave and conscientious at his work, but full of the joy of living, he was a boy again on his fishing trips and vacations; a genial host, whose beaming face and hearty laugh drove care away. Few things could ruffle his even temper, but righteous indignation was always roused by shams and lies, and fanatical attacks on scientific medicine. His memory will live as a great teacher, a great physician, a great *man*.

384 Post Street.

CLINICAL NOTES AND CASE REPORTS

MULTIPLE CONGENITAL ABNORMALITIES*

By N. Berwyn Lawrence, M.D.
Colton
AND
E. Harold Shryock, M.D.
Loma Linda

WE present herewith a case of congenital malformation in which there were so many separate deformities, and some of the deformities were so extreme, that we feel the report may be worthy of publication.

REPORT OF CASE

The case was that of a fetus which had undergone about thirty-two to thirty-four weeks of development. It was delivered in the home on November 21, 1936, by Doctor Lawrence. The family consisted of a father and a mother, each aged 26, and two healthy children, aged, respectively, four and six. Both parents responded negatively to the Wassermann reaction, and there was no history of abortions or miscarriages, nor was there any history of congenital malformations among the known relatives, except that one child in the immediate family has a small cervical cyst.

Aside from the delivery being somewhat premature, the first observation of note at the time was that the presentation seemed to be that of the breech. Vaginal examination appeared to confirm the idea of a breech presentation, but indicated that there was no true gluteal cleft, thus making the operator suspicious of an imperforate anus. The usual amount of amniotic fluid was apparent at the delivery.

External Deformities.—At the completion of delivery the following externally apparent deformities became evident: imperforate anus, absence of left lower extremity below the knee joint, the left hand consisted of but two digits (the thumb and first finger), webbed left elbow (left forearm could not be extended), right talipes varus, absence of penis, and absence of the urethral orifice.

The child breathed a few times, tried to cry, and then spontaneously ceased to breathe.

X-Ray Studies.—Before performing an autopsy the accompanying photographs were taken and a complete x-ray study was made by Dr. Elizabeth J. Hiscox, roentgenologist at the Loma Linda Sanitarium. The x-ray studies indicated an absence of all the bones of the left leg (the patella was present and just beginning to ossify), absence of the left ulna, absence of those metacarpal bones and phalanges corresponding to the absent medial three digits of the left hand (the carpal bones, as yet, showed no ossification), a typical talipes varus on the right, and an incomplete development (approaching an absence) of the sacrum and coccyx.

Autopsy.—The autopsy was performed by Dr. Oran I. Cutler, Professor of Pathology at the College of Medical Evangelists. It revealed that the lungs had never been inflated, but that, due to a tracheo-esophageal fistula, the stomach had been filled with air at the time the child took a few breaths. Also, the right lung consisted of but a single lobe. There was a small accessory spleen, no gall bladder could be found, and the large bowel terminated abruptly at a point corresponding to the junction of the sigmoid and rectum. The testes had not completed their descent, one being found in an inguinal canal and the other within the pelvic cavity. Although the suprarenal glands were present, there was, grossly, an entire absence of both kidneys, both ureters, the bladder, and the urethra. There was observed a small duct extending between the umbilical aperture and the blind ending of the large bowel. This was interpreted

* From the Department of Microscopic Anatomy, College of Medical Evangelists, Loma Linda.



Fig. 1



Fig. 2



Fig. 3

Fig. 1.—Complete absence of anal opening and gluteal cleft.

Fig. 2.—Amputation of lower left limb just below the knee joint. Web formation between left arm and forearm, and showing presence of only left thumb and index finger.

Fig. 3.—Showing absence of penis, and right club foot.

to be the urachus. The skull was not opened, but no deformities of the head were externally apparent.

Microscopic Findings.—A section taken from the wall of the urachus revealed, upon microscopic examination, some fragments of transitional epithelium. Sections were also taken from a small multicystic structure found just below the left suprarenal gland. These showed many small epithelial lined structures which, it was thought, might be rudimentary kidney tubules.

COMMENT

Perhaps the most striking anomaly present in this case was the absence of the urinary system. Not only would this seem to indicate that the kidneys of a fetus are not necessarily active during even the latter months of intra-uterine life, but it would seem to furnish conclusive evidence against



Fig. 4



Fig. 5

Fig. 4.—Various views of the bony abnormalities, as well as of entire fetus, viewed posteriorly.

Fig. 5.—Lateral view of infant showing ossification centers in proximal end left tibia, and complete absence of ulna in left forearm.

the old theory that the amniotic fluid is the product of the fetal kidneys; for, in this case, in spite of the absence of even a urethral orifice, there was a normal amount of amniotic fluid present.

The tracheo-esophageal fistula was evidently the immediate cause of death. Had it not been for this deformity, either the absence of the urinary system or the absence of the rectum with the associated imperforate anus would, of course, have produced death within a relatively few hours. The other deformities found would, presumably, have been consistent with life.

The only clew as to the possible cause of the many deformities exhibited in this case is the admission by the parents of the use of a chemical contraceptive prior to conception. Whether or not we are justified in assuming that, under such circumstances, injury to the germ cells may result in congenital deformities, is problematical.

SUMMARY

The case presented is that of a fetus of about thirty-two to thirty-four weeks of development, in which approximately eighteen single deformities were noted. Included in this list of deformities are the virtual absences of all of the essential parts of the urinary system.

Arcade Building, Colton.
College of Medical Evangelists, Loma Linda.

IODODERMA DUE TO LIPIODOL*

By Saul S. Robinson, M.D.
Los Angeles

THE injection of iodized oil in the form of lipiodol has been employed since 1922 for bronchography and other diagnostic procedures.[1] In 1927, Belote[2] of the University of Michigan reported the first case of iododerma following a lipiodol injection. O'Donovan,[3] Carmichael[4] (two cases), Scadding[5] (two cases), and Goldstein[6] have since recorded six additional cases of iododerma following the injection of iodized oil. There have been no case reports from California. Two of the reported cases have been fatal and indicate the severe idiosyncrasy that a patient may show to lipiodol. A fatal issue may depend on the combination of a marked iodin idiosyncrasy and the large amount of iodized oil usually injected for diagnostic purposes (20 cubic centimeters). Because of the widespread use of lipiodol and the severity of the iododerma that may result from its administration, the following case report is considered of interest.

REPORT OF CASE

Mr. H. K., aged 60, consulted me on May 13, 1937, because of an eruption that had appeared on the previous day over the trunk, the neck, and the extremities. No subjective symptoms were associated with the skin lesions. The past history revealed that the patient had suffered from a cardiac and a bronchial disorder, and on April 26 he had been given an intratracheal injection of 20 cubic centimeters of lipiodol for bronchography. The patient had been in good health since the injection, but complained of a disagreeable taste, probably due to the coughing up of the iodized oil. The only medication taken internally had been theominal for cardiac pain.

The dermatologic examination revealed a discrete, erythematous, pinhead to pea-sized maculopapular eruption located on the chest, back, neck, upper extremities, and the thighs. No lesions were present on the mucous membranes of the mouth and the throat. No adenopathy was present. The Wassermann and Kahn reactions on the blood serum were negative. The urine showed a strongly positive test for the presence of iodin.

The dermatologic diagnosis was iododerma following an intratracheal injection of lipiodol. Enteric-coated sodium chlorid tablets in the doseage of 15½ grains three times daily were given, with rapid clearing of the eruption. The theominal was administered with no effect on the eruption.

COMMENT

The elimination of iodin from the body after an intratracheal lipiodol injection is effected mechanically and by absorption through the usual body channels. Mechanical elimination of the iodin occurs by coughing up and expectorating the iodized oil. Moeller and Von Magnus[7] found iodin present in the urine as early as six hours following a lipiodol injection. These investigators reported the peak of urinary iodin excretion to occur in twenty-four hours, with iodin absent after six days. Iglauer[8] also reported the absence of iodin in the urine after six days, with the presence of iodized oil in the lungs for many weeks after the injection. It is interesting to note, in view of the above findings, that my patient's urine contained iodin eighteen days after the lipiodol administration. This delayed iodin excretion may account for the delayed appearance of the iododerma in my case.

The infrequency of severe iodism and iododerma following lipiodol injection is probably due to the stable chemical combination of the iodin and the unsaturated fats in lipiodol. Lipiodol consists of a 40 per cent solution of mettaloid iodin in neutral poppy-seed oil. Cases of iododerma from iodized oil have been reported where the patients had received iodin previously in other forms such as potassium iodid without manifesting idiosyncrasies to the drug, but developing iododerma after a lipiodol injection. Inasmuch as severe iododermas may occur from lipiodol, it is unfortunate that there is no method of determining iodin idiosyncrasy in patients before the lipiodol administration.

1930 Wilshire Boulevard.

* From the Department of Dermatology, Cedars of Lebanon Hospital, Los Angeles.

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BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

SURGERY AND SYPHILIS

I. SYPHILIS IN RELATION TO GENERAL SURGERY

Charles Eaton Phillips, M. D. (2007 Wilshire Boulevard, Los Angeles).—The incidence of syphilis can only be estimated, as there are no statistics available to show its extent. The American Social Hygiene Association estimate that 5 per cent of the population are syphilitic. Such an estimate, from that source, is probably essentially correct.

Many diseases, such as smallpox, yellow fever, plague, puerperal fever, malaria, tuberculosis, and others, destroy a greater percentage of those infected, yet their deadliness is recognized and feared, and their ravages have been stopped by scientific medicine. Our knowledge concerning syphilis, its cause, course, symptoms, and methods of relief and cure, are as comprehensive as our understanding of any of the other deadly diseases, and yet we have not checked its ravages to any extent.

Destructive Action of Syphilis.—It still stands in the front rank of diseases destroying the race. There are reasons for this condition. First, let us list the difficulties of detection. A person may be suffering from syphilis in a contagious form, and still not show any characteristic symptoms which would warn those who might come in contact with him. Syphilis may be transferred before the symptoms of the disease become manifested. It may be contracted, and the person may not be aware of the infection until long afterward, when the disease is firmly established and a cure impossible.

The second reason for the spread of syphilis is that a little treatment will frequently clear up the early symptoms, and the patient goes on (ignorantly or carelessly) spreading infection. Many times the syphilitic patient receives treatment before a definite diagnosis is made. Neither the doctor nor the patient knows what the patient has, and as soon as the symptoms are relieved the treatment is stopped and the patient eventually dies of syphilis.

The fallacy that the infection can be stopped by an early cauterization of the initial sore is responsible for many cases which could be cured by adequate treatment in the early stage of the disease. It has been shown, since the discovery of the treponema, that the infection becomes widely diffused in the body almost from the first, and any kind of local treatment is entirely unavailing in an attempt to stop the disease before it becomes systemic.

Many initial sores are overlooked or, if seen, are not recognized. The difference between the number of those known syphilitic and the number who show the presence of the infection by its late manifestations, illustrate the dangers of overlooking syphilitic infection.

In 1924, Newsholme estimated that the annual death rate from known syphilis was one hundred and eighteen per million, or a total of about four thousand in England and Wales.

Osler (1915) estimated, in the same geographic limits, that the effects of syphilitic infection, neurologic, and cardiovascular were responsible for sixty thousand deaths, or fifteen times as many as were recognized as syphilitics. When we add to this number the sterilities, abortions, miscarriages and, worse than all, the mentally and physically unfit due to syphilitic infections, then we can see the appalling destruction that is due to syphilitic infection, and how it occupies a position as the most destructive disease affecting the human race.

In the Johns Hopkins Hospital Medical Service, where the Wassermann test is obligatory on every patient admitted, syphilis appears in 20 to 25 per cent of all colored patients, and from 7 to 10 per cent of the whites. One would expect the incidence of the disease to be considerably higher on the medical service than on the surgical side; yet the number of unsuspected cases that appear shows the necessity of continual vigilance in every department of medicine and surgery.

According to Albert Keidel, life insurance data show that among insured syphilitics there is a mortality of 168, compared with a rate of 100 covering all classes of insured persons, including the syphilitics. The same author states that 25 per cent of patients with recognized but untreated syphilis of more than two years' duration will have central nervous system involvement, and that from 40 to 80 per cent of such cases will have cardiovascular damage sufficient to lower their reserve.

Surgery in syphilitics is attended with an element of uncertainty. Active, untreated syphilis contraindicates all except absolutely emergency surgery. The syphilitic with infection under control offers no particular problem to the surgeon, and but slight increase in risk. Patients with latent untreated syphilis show a rate of danger distinctly higher than that in uninfected cases.

Danger of Syphilis in Surgery.—Syphilis offers a threefold danger in surgery:

First, it leads to errors in diagnosis. Nuzum, in a survey of one thousand operations in known syphilitic patients in the Cook County Hospital, found that ninety-seven useless and unnecessary operations had been performed on eighty-seven patients. Gastric ulcer, gall-bladder disease, appendicitis and salpingitis headed the list (Dean Lewis Surgery). When so many errors are made by competent surgeons in those known to be syphilitics, we can only surmise the mistakes of the less

skillful where syphilis is unknown and probably unsuspected.

On the other hand, the presence of a syphilitic infection is no assurance that the patient may not be suffering from other diseases at the same time. Many a case of known syphilis has suffered from disease of the gall bladder, appendix, salpingitis or other acute surgical diseases, and on account of the known infection operation has been delayed too long.

Secondly, there is an increase of the immediate mortality rate attending surgery. This can only be estimated by the lowered resistance of infected patients, and the less expectancy of life as shown by the life insurance statistics.

Thirdly, syphilis makes for an interference with the healing of wounds in a certain percentage of surgical cases which have been insufficiently treated. To illustrate: A young lady of twenty-five years was operated for the relief of a chronic pelvic inflammatory disease. There was no history of syphilis. There was a history of taking "shots" for anemia. The Wassermann was negative. Following the surgery, there was an uncomplicated recovery until the tenth day. The stitches had been removed and healing had seemed satisfactory when the edges of the incision began to necrose. A thin line of dry gangrene appeared along the edges of the wound. The Wassermann was repeated and found to be positive. Antisyphilitic medication caused prompt healing.

We can see the necessity of requiring a routine Wassermann in all cases admitted to hospitals. The negative history and the routine physical examination are not sufficient assurance that the patient is not infected with syphilis. A disease causing more trouble than any other is worthy of the utmost care in its treatment and cure. While the serologic tests do not always show the presence of existing syphilis, their routine use would do much to eradicate the disease.

Social Phases.—The stigma that attends infection with syphilis is one of the chief reasons for hiding its presence. Few, who find they are infected, are in a position to carry on treatment for a sufficient time to insure even a relative cure without sharing their secret with someone else. If, for no other reason, the expense of the treatment and the necessary precautions that must be taken are sufficient to betray their secret. Rather than divulge their secret, they are tempted to stop treatment when their symptoms are relieved and before a cure could be hoped for.

The injustice of the present system is apparent when we consider the way different crimes against society are punished. The careless individual throws a stone into a crowd and accidentally puts out an eye or scars a face. The offender is fined an amount commensurate with his ability to pay. He may be incarcerated for his act. The same careless individual infects with syphilis. There is no redress, although the patient's entire life may be ruined, as well as that of any offspring.

Possibly a young girl is betrayed and bears a child. The father of the child is held responsible for her condition. He is required to recompense her by marriage and support, or may pay money to support her and her child, as far as he is able.

In the event that he infects her with syphilis, he places a lifelong stigma on her, and yet is not held accountable for his act. The infection not only ruins her life, but also that of any offspring she may have subsequently.

In Conclusion.—Syphilis increases the hazard of operations and jeopardizes the result of surgery. Active syphilis should contraindicate all except emergency operations. The shock of surgery may activate latent syphilis.

A single negative serologic test is no assurance that the patient is free from syphilis. A negative history is of little importance regarding syphilitic infection. Family traditions, social position, religious affiliations, or absence of a history of specific infection cannot be accepted proof of freedom from the infection.

The cure of syphilis is problematical. When the case is seen early and treatment is adequately administered for a year and following, there should be check-up examinations every three months without any treatment. If these tests remain negative for the year, and the spinal fluid Wassermann, cell count, globulin, titrated Wassermann and colloidal are negative, the case may be considered clinically cured. There is no assurance that the cure will be permanent, and Wassermann tests should be taken at intervals for at least ten years. Spinal fluid tests should be repeated on the first untoward symptoms as long as the patient lives.

The prevention and final eradication of syphilis is possible only if the transmittal of syphilis is recognized as a crime and punishable by law.

A negative Wassermann test before marriage, while it is a step in the right direction, is not sufficient to control the disease. Syphilis is spread by many who are not interested in marriage.

Syphilitic infection, even if not transmitted, must be recognized as a misdemeanor and quarantinable unless adequate treatment is being taken. Treatment must be made available to all infected cases.

* * *

II. SYPHILIS IN RELATION TO INDUSTRIAL MEDICINE

Harry E. Alderson, M.D. (490 Post Street, San Francisco).—Industrial dermatoses occur in all trades and occupations, but it is mostly in certain vulnerable individuals that they are seen. Advancing years (past forty), congenitally thin or susceptible skin (allergy), and various underlying constitutional diseases are important factors. Under the last heading, syphilis may be listed as a fairly common cause. Syphilis at all stages not only tends to make the worker less careful, but on account of the tendency that even the latent syphilitic's skin shows to develop syphilomata at the site of traumatism, it often has to be con-

sidered. Also syphilis may at times retard the healing of wounds. So this disease renders its victims poor industrial risks.

Two cases in point were reported by me in 1931.[1]

Case 1.—Mr. C. C. (No. 25948), a Mexican carpenter, thirty-nine years old, presented a typical, non-ulcerating gumma, extending across the left upper orbital margin. There was a similar smaller lesion at the inner end of the right eyebrow, which had been present for several months. The former lesion appeared shortly after the patient was injured in that spot by a piece of lumber on which he was working. An abrasion resulted and it never healed, developing finally into a typical syphiloma. There was no history of syphilis, and the only other evidence found was a strongly positive blood Wassermann. Under neoarsphenamin and bismuth the lesions disappeared.

Case 2.—Mr. P. C. (No. 25190), an Italian laborer, thirty years old, presented a typical, non-ulcerating syphiloma at the right inner canthus. His blood Wassermann was strongly positive. It was impossible to obtain a history or other evidence of syphilis. About two months previously, while cutting wood with a "rip saw" a splinter of wood struck the side of his nose near his eye. The patient pulled out the splinter, and there was some bleeding. The wound never healed, and the syphiloma gradually developed. Under neoarsphenamin and bismuth injections it subsided rapidly.

In each of these two cases responsibility was accepted by the insurance carriers, and the necessary treatment to eradicate the lesions only was authorized.

The following case record, taken from the United States Public Health Reports of 1916, and the quoted court decision, establishes the status of these cases:[2]

A workman was injured by an accident in a sawmill at Traverse City, Michigan. Under the Workmen's Compensation Law, payments were made for a period of nineteen weeks, when the employer refused to make further payments, upon the ground that the employee's continued disability was due to syphilis, which retarded the healing of the wound.

The Michigan Supreme Court, however, decided that payments must be continued. Mr. Justice Person, in the opinion, said: "The consequences of the injury extend through the entire period, and so long as the incapacity of the employee for work results from the injury, it comes within the statute, even when prolonged by preëxisting disease."

Numerous decisions have placed on the insurance carrier the responsibility for medical care of syphilitics who have developed syphilomata as a result of vocational trauma or irritation. (See Klauder[3] and Harry Foerster.[4] Foerster[4] comments as follows:

"Compensation is not dependent on any implied assumption of perfect health, and does not exclude the weak or physically unfortunate, or those with latent and unknown tendencies to disease. The employment of a man is in itself an assumption that he is physically and mentally fit for the work."

Klauder[3] cites numerous examples where traumata of various kinds have determined the appearance of syphilomata at the site of injury. There is to be remembered also the often-quoted example of the occurrence of gummata on the foreheads of Mohammedans, who in their religious ceremonies frequently strike their heads on the marble floor.

With syphilis so prevalent, many of the cases having had inadequate treatment, it is rather discomforting to realize that in positions of responsibility there may exist cases of latent and of neurosyphilis. Stokes[5] reported, in over one thousand cases, eight times as many syphilitics among railroad men as among farmers! His article, which discusses also cerebrospinal complications, is of very great interest. Various other writers have stressed the great prevalence of syphilis among railroad workers, and such workers are frequently exposed to trauma.

Whether or not syphilis is acquired innocently or through carelessness, any occupational dermatoses that may be aggravated by the disease has to be taken care of by the insurance carrier. It would be wise, and perhaps would be the means of lessening disability and saving expense, if every patient with occupational troubles had a Wassermann test done at once.

* * *

III. SYPHILIS IN RELATION TO EYE INJURIES

Hans Barkan, M.D. (Stanford University Medical School, San Francisco).—It is not an unusual event to find the eye specialist treating an eye inflamed and injured without realizing that the manifestations of the injury may not be due to the direct effects of the trauma alone, but are complicated by the fact that they are partially manifestations of syphilitic processes aroused to activity by the trauma. When one considers the number of dormant syphilitics in the community, one is rather surprised that not more syphilitic post-traumatic manifestations are seen than is the case. To illustrate the point: Only very rarely, if ever, does the eye of a syphilitic, when operated upon for glaucoma or cataract, show any other than a normal course of healing. When, however, the trauma is a blunt one, such as a blow from a piece of wood, or a lead shot striking the cornea, or an eye hit by a piece of swinging rope, just to mention three personal cases, it must be borne in mind that the injury may arouse specific manifestations in an eye so predisposed.

1 Alderson, Harry E.: Syphilis in Relation to Occupational Injuries, Calif. and West. Med., Vol. 35, No. 6 (Dec.), 1931.

2 United States Public Health Reports, Vol. 31, No. 39 (Sept.), 1916.

3 Klauder, Joseph V.: Syphilis and Trauma, J. A. M. A., 78:1029-1037 (April 8), 1922.

4 Foerster, Harry R.: Industrial Dermatoses, Arch. Dermat. and Syph., 17:585-601 (May), 1928.

5 Stokes, J. H., and Brehmer, H. E.: Syphilis in Railroad Employees," J. Indust. Hyg., 1:419 (Jan.), 1920.

The most frequent of these is interstitial keratitis. Of these, I have seen four cases, published in the *Transactions of the American Ophthalmological Society* in 1926. The patients were all congenital luetics in their thirties and forties, at an age when interstitial keratitis as a congenital manifestation does not occur. In the injured eye in each case there developed, within a week after the injury, a typical keratitis, and in each case the second eye followed after several weeks or months, just as spontaneous cases in children do.

Iritis not infrequently follows a very trivial external injury, and is usually characterized by a severity out of all proportion to the external blow on the lids or eyeball. In one case I saw it develop as a typical iritis papulosa.

Blows of minor severity on or about the eye can be followed by periostitis of the supra and intraorbital margins as luetic manifestations. I have seen only one instance of this. Igersheimer, in *Syphilis und Auge,* states that luetic retinitis, choroiditis, and neuritis may follow blunt trauma in the luetic, but it seems to me that these sequelae, while they may occur, must be very rare and isolated cases.

The main interest, for practical purposes in the coincidence of trauma and syphilis in the eye, consists in the fact that a number of patients claim compensation disability, and we are occasionally asked to act as referee in such cases. The position I took in regard to this in several instances is as follows: First, the case must be seen on the day or not later than two or three days after the injury, so that the primary effect of the injury is still evident, and examination of the cornea and iris discloses that the process is not one distinctly antedating the injury. Second, the injury must be sufficient, and we must take our stand firmly against such injuries claimed as dust in the eye, exposure to wind or draft, cocain or atropin in the eye, conjunctivitis, etc. In review of the case which must be accepted, the trauma has always been a forcible striking of the corneal tissue, even though by a small object involving the breaking of the continuity of the tissue, or a blow of sufficient severity to cause deep hyperemia and disturbance of the lymphatic circulation of the eye. Third, the luetic effects must appear in a week or two after the injury, and fourth, the process must be typical, so that no doubt of the diagnosis can arise.

If we assume that the relationship of trauma to interstitial keratitis is only accidental in time, there is no such problem to be considered. We simply deny that interstitial keratitis is the result of any claimed trauma. If we believe that there are enough authentic cases, ruling out all cases of trifling injuries, conjunctival inflammations, nonirritating chemical or gaseous contact with the cornea, such as soap, atropin, etc.; and ruling out, also, many reported cases which were probably not interstitial keratitis at all—if, doing all this, we are still convinced that there are enough legitimate cases to establish beyond question the fact that trauma is of etiologic moment, we must maintain in such a case that the particular trauma can cause the luetic eye manifestation, and that, consequently, all the time of the disease is compensable, and the permanent loss of vision, to be estimated one year after the last inflammatory symptoms have disappeared, to be compensated.

Coutard's Method of Treatment of Cancer.—Since the results of Coutard therapy in the treatment of cancer of the larynx, pharynx, and hypopharynx have been so far superior to any present or previous method, Chamberlain and Young believe that no other procedure should be considered when roentgen treatment for the disease at these sites is indicated. The same statement holds for cancer in certain other organs, for example, the cervix, breast, bladder, esophagus, bronchus, and rectum, although it is often necessary to modify the dosage, depending on the size and location of the tumor and the condition of the patient. In those lesions which respond to Coutard therapy better than to "massive doses," the advantage of the protracted fractional dose method must rest on the existence of a more rapid "recovery rate" in the skin than in the tumor. There are tumors requiring massive doses just as surely as there are tumors that require the method of Coutard. Certain small superficial growths are completely destroyed by a single large dose of from 3,000 to 5,000 roentgens with complete assurance that the resultant ulcer, of small size, will heal completely; for example, a small or moderate-sized, isolated nodule of recurrent mammary cancer in an accessible or superficial location. A plan of monthly doses of from 300 to 800 roentgens (usually in a three- or four-day series) is considered by the authors whenever they are faced with (1) a highly roentgen resistant tumor and a microscopic structure that indicates a high degree of tissue differentiation (fibrosarcoma, neurofibroma, metastasizing thyroid adenoma) or (2) when the element of vascularity is an important factor (hemangioma, certain telangiectatic tumors of the spinal canal, some highly vascular but relatively radiation-resistant sarcomas of the bone). While the literature appears not to contain any analytic references to this type of technique, it is obvious that Newcomet, Ewing, Ginsburg, and others, have consciously or subconsciously adopted some such method.—*Radiology.*

The Art of Thinking.—Whoever lacks a ruling interest will fail to make the most of his mind; for without such training and experience as the long-continued pursuit of a subject gives, the intellect does not develop its power. Nor will the man of too many interests grow to his full mental stature. Mental growth in mature life, as shown by Spinoza and other examples, is fostered by nothing so much as an absorbing aim.

He who has a liking for a science or an art, for a branch of literature or period of philosophy, for the life of a great man, the history of a people, or other line of inquiry, is already on vantage ground. He is in a position to gain both insight and outlook. A point here and a point there will be located by the aid of which he may not only survey his own field, but also orient himself in wider provinces of knowledge. Thus he may hope to find some of the fundamentals of truth and life.

Through coping with problems, through investigation, reflection, and discussion, he will learn how to think. Meanwhile he will have a joy in books unknown to the haphazard reader; he will see more in life and the world than meets the casual eye. His days will be remote from the tragic need of killing time, for his leisure will be full of contentment, often of happiness and zeal.—Leon J. Richardson.

Adult education is in one sense a youth movement. Consider the countries involved. They are mainly the ones where English, the Scandinavian languages, German, and French are spoken. This fact is significant. In science, literature, and other fields of sound thinking, the peoples using these languages take high rank. They are progressive, giving much attention to the problems involved in bettering human life.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

HOWARD MORROW.....President
WILLIAM W. ROBLEE.....President-Elect
LOWELL S. GOIN.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Council Meeting.*
2. *Annual Dues.*
3. *American Medical Association Secretaries and Editors' Annual Conference.*
4. *Panel Jobs and Cut-Rate Fees.*
5. *Read Your Liability Policies.*
6. *Postgraduate Conferences.*
7. *Council on Industrial Medicine and Surgery.*
8. *Permanent Endowment Fund.*
9. *Membership.*
10. *Executive Committee Minutes: Digest.*
11. *Passing Comment.*
12. *Drug-Sample Rackets.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Cut-Rate Fees.*

ASSOCIATION ACTIVITIES

COUNCIL MEETING

The Council of the California Medical Association will convene in regular session in Los Angeles on Saturday, January 15, 1938, at 9:30 a. m. The meeting will be held in the Lounge of the Los Angeles County Medical Association headquarters building.

Any county society, committee, or member having any proper matter requiring consideration by the Council is requested to transmit their question to the State Secretary.

ANNUAL DUES

January, marking the beginning of a new year, is the month during which members should pay their annual county and state dues for the current year.

The State Association dues for 1938 were reduced from $15 to $10 by the House of Delegates at the Del Monte annual session, and are payable this month to your county secretary, who will remit to the State Association offices. In due course you will receive your state membership certificate.

It is suggested that you remit your county and state dues to your county secretary today. Relieve him of the extra labor of having to assume the rôle of collector. *Send him your check today.*

AMERICAN MEDICAL ASSOCIATION SECRETARIES AND EDITORS' ANNUAL CONFERENCE

The Association's editor and secretary attended this conference at the American Medical Association headquarters in Chicago on November 19 and 20. The following constituted the formal program, and was productive in transmitting much helpful information as to activities of state organizations.

ANNUAL CONFERENCE OF SECRETARIES OF CONSTITUENT STATE MEDICAL ASSOCIATIONS, 1937

American Medical Association Building
535 North Dearborn Street, Chicago

PROGRAM

Friday, November 19, 10 a. m.

Call to Order. Arthur W. Booth, Chairman, Board of Trustees of American Medical Association.

Address. J. H. J. Upham, President, American Medical Association.

Student Health Services: A Challenge to Medical Societies. J. D. Laux, Bureau of Medical Economics of American Medical Association.

Extension (Postgraduate) Courses of State Medical Associations. Walter F. Donaldson, Pittsburgh; Creighton Barker, New Haven, Connecticut; T. W. M. Long, Roanoke Rapids, North Carolina; Holman Taylor, Fort Worth, Texas.

The Uses and Benefits of Exhibits Under Auspices of State Medical Associations. Eben J. Carey, Milwaukee.

12:30 p. m. Luncheon.

Friday, November 19, 2 p. m.

Address. Irvin Abell, President-Elect, American Medical Association.

The State Association and the Social Security Act:
New Jersey's Coöperative Program for Maternal and Child Health. LeRoy A. Wilkes, Trenton, New Jersey.
Coöperative Program of the Illinois State Medical Society. Harold M. Camp, Monmouth, Illinois.

The State Association's Part in a Pneumonia Control Program. Peter Irving, New York.

Friday, November 19, 6:30 p. m.

Palmer House

Dinner Meeting of Editors of State Medical Journals. E. M. Shanklin, Hammond, Indiana, Presiding.

Better Papers for State Medical Journals. J. H. Dempster, Detroit.

Round-Table Discussion:
Publication Costs.
Typographical Arrangement.
Cross References.

Saturday, November 20, 9:30 a. m.

Two Important Legal Problems: Malpractice Claims; Taxation Under Federal Revenue Acts and Social Security Act. W. C. Woodward, Director, Bureau of Legal Medicine and Legislation of American Medical Association.

Topics for General Discussion:
Secretary's Bulletins for Officers or Members.
By-Laws Pertaining to Membership and Disciplinary Measures.
Rural Rehabilitation Plans of Federal Government.
Independent Societies.
Automobile Accidents.

Editorial comment and letters published in the December issue transmit to each reader the serious question that concerned the conference. Every member should carefully read the editorial and the communications and devote time in consideration of their portent.

Under the democratic plan of our medical organization, channels and methods have been created for the presentation and consideration of any principles, policies or plans that any member, individual or groups of members or individuals may feel should receive attention and action.

That which organized medicine has accomplished has been attained through these channels by constituted representatives. The channel is an open one, and is continuously operative.

Independent or coterie action is disorganized action and as such is unwise, and deserves no support.

Need more be said than to remind all members that our organizational strength and unity is the more potent force in conserving our individual and collective future. Let that thought remain uppermost when independent proposals are presented to medical men.

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

PANEL JOBS AND CUT-RATE FEES

Members are approached from time to time by representatives of corporations, insurance companies, lay groups and organizations seeking to secure medical services at bargain rates, greatly reduced from the prevailing schedule.

Within the past month county societies and individual doctors have been approached by an Automobile Insurance Company representative seeking to secure medical services, when needed, for its policyholders. The representation is made that if the doctor will render medical and surgical care to these policyholders for fees 25 per cent below the present compensation fee schedule, his name will be placed on the panel of the insurance company doctors and this business will be sent to him.

The old bait! One for which the unthinking doctor will fall, and be the sucker while the company pockets increased profits at the doctor's expense.

Compensation fee schedules are now below the regular fee schedules. Why should you accept a still further reduction under the sales urge of the company that paints pictures of increased volume of practice and income? Why should a company seek reduced fees, prey upon the doctor, lower his just income and seek these exceptions and favors? Simply to lower their liability expenses, lessen their costs and increase company earnings and dividends at the expense of the doctor.

In all such quests and approaches the member should refer the entire matter to the officers of his county medical society and abide by the policy of his society. There must be no cut-rate fees. Do not fall for the gush of these representatives who hold out the bait of increased volume of exclusive business, special qualifications, etc.

Before signing up, consult your county secretary. Do not undercut your fellow practitioners.

READ YOUR LIABILITY POLICIES

Again we have seen this month three policies issued to members and which these members thought gave them adequate insurance protection. They did not! Exceptions and noncoverage were for "*nonemergency* operations," protection defense only for suits arising "*within* the year the policy was in force" and not for suits brought from one to two years later or in the instance of minors who can start a suit within two years after they attain their majority. A hidden clause wherein the company can settle without consulting the holder of the policy.

Hence the warning is issued anew! Read your policy and learn if you have adequate protection.

POSTGRADUATE CONFERENCES

On December 2, the first postgraduate conference under the new five-year program of the Association was held in Eureka. Thirty of the thirty-four members of the Humboldt County Medical Society attended. Three of the members drove 176 miles to participate in this conference.

Dr. Stacey Mettier of the medical department of the University of California presented the subject of arthritis. Dr. H. Glenn Bell of the same school covered the subject of acute involvement of the gall-bladder.

Councilor Henry Rogers and the State Secretary presented the outline of State Association policies and activities.

* * *

On December 9, President Morrow, Councilor Rogers, and the State Secretary were speakers at a well-attended meeting of the Marin County Society. Doctor Morrow presented a lantern-slide clinic on syphilis and discussed State activities in venereal disease control and treatment. Councilor Rogers and the Secretary discussed Association activities.

It was an excellent meeting, but in an unusual heavy rainstorm the President and the Secretary made a wrong turn and got off the road and became mired in a ditch and almost two-mile walk in a drenching rain to a telephone brought the County Secretary with a chain. However, power was lacking to pull the car back on the road, so it was abandoned temporarily and journey resumed in the County Secretary's car, and here another but—he, too, got lost in the hills in his own bailiwick. Aimless driving eventually landed us in his own city where, oriented anew, he delivered us at the meeting place some two hours late and two state officers thoroughly soaked—with water from shoulders to feet, but even this did not dampen a very interesting and worth while evening meeting of the Marin County Medical Society.

COUNCIL ON INDUSTRIAL MEDICINE AND SURGERY

A resolution passed by the American Medical Association House of Delegates last June directed the Board of Trustees to appoint a Council on Industrial Medicine and Surgery. The following appointments have just been announced: Stanley J. Seeger, Milwaukee, Chairman, Harvey Bartle, Philadelphia; Warren F. Draper, Washington, D. C.; Leroy U. Gardner, Saranac Lake, New York; Morton R. Gibbons, San Francisco; Henry H. Kessler, Newark, New Jersey; A. D. Lazenby, Baltimore; Earl D. Osborne, Buffalo; and C. W. Roberts, Atlanta, Georgia. The Council held its first organizational meeting in Chicago on December 10.

Our congratulations are extended to Dr. Morton R. Gibbons, Sr., on his appointment as a member of this Council. Doctor Gibbons' ability and long years of experience will make him a most valuable member and give assurance that this newly created Council will accomplish needed regulations, policies, and results. California's profession is gratified by Doctor Gibbons' appointment because it is felt that these peculiar problems in California will receive careful consideration.

PERMANENT ENDOWMENT FUND

Contributions to date—$200 from two members! A rather disheartening response to the several editorials and items in previous issues. Surely, there are 998 members who can subscribe $100 or more to establish this permanent endowment fund, whose principal will remain intact in perpetuity. Will *you* be one of them?

The income earnings of this fund will be appropriated to defray the expanding activities of this Association, particularly our five-year postgraduate program opportunities and the program of public education.

Please pause and consider what amount you can subscribe to this fund and remit it today. One hundred dollars—or one thousand, and maybe more. The Council urges that you aid in establishing this fund.

MEMBERSHIP

Because occasionally misunderstanding and confusion arises regarding the status of members in their county and state medical organizations, the Constitution and By-Laws governing membership are reprinted:

Article IV.—Membership. (a) Active Members. Qualifications.—Active members shall comprise all active members of all the component county societies. No person shall be eligible for election to active membership in a component county society unless he shall hold the degree of doctor of medicine issued to him by an institution of learning accredited at the time of conferring such degree by the American Medical Association or the Association of American Medical Colleges. He must also hold an unrevoked license to practice medicine and surgery in the State of California; provided, however, that, subject to the minimum qualifications prescribed by this Constitution and the By-Laws, each component county society shall be the exclusive judge of the qualifications of the members thereof.

Membership in the American Medical Association does not, *ipso facto,* mean that one is a Fellow of the American Medical Association. To be a Fellow of the American Medical Association, one must make special application and pay an additional $7 to the American Medical Association for fellowship annual dues. The perquisites of fellowship are: (1) Receiving the *Journal of the American Medical Association.* (2) Admission to all the exhibits, general and section sessions of the annual meeting. (3) Right to participate in the scientific meeting programs. (4) Eligibility to appointment or election to offices, councils, committees and bureaus, and membership in the House of Delegates.

Many members are under the impression that they are Fellows because they subscribe to the *Journal of the American Medical Association* and remit $7 annually. It is imperative that you apply for fellowship. If you are a

Fellow you will receive a Fellow's pocket card, necessary to register at an annual session and gain admission to *all* annual functions.

Search your wallet or files and ascertain if you have a fellowship card. If not in your possession, then it is recommended that you file the proper application—obtainable from your county secretary or your state secretary.

EXECUTIVE COMMITTEE MINUTES: DIGEST

The Executive Committee of the Council met in San Francisco on December 11.

1. Malpractice liability insurance questions were referred to the Committee on Malpractice, to report on January 15, 1938.

2. Secretary authorized to reissue charters to county societies whose original charters were lost.

3. A Mexican vacation tour was sponsored.

4. Membership Roster of 1937 was ordered published as a supplement to the February journal.

5. Hospitalization plans of Southern California Associated Hospitals was referred to Committee on Public Relations for report on January 15, 1938.

6. Qualifying Certificate Committee requested to submit detailed report on January 15, 1938.

7. Routine matters discussed and acted upon.

8. January 15, 1938, was fixed as date for the next regular Council meeting in Los Angeles.

F. C. Warnshuis, *Secretary.*

PASSING COMMENT

It costs the government $900,000 per year for treatment of men in the ranks of the CCC for venereal infections.

* * *

The "Elixir Sulfanilamide Tragedy" has caused some stir in congressional circles. It is hoped that this tragedy and loss of seventy-three lives will induce Congress to enact needed legislation to control the manufacture and sale of potent drugs and remedies. Write to your United States senators and congressmen urging their support of this needed legislation.

Drug manufacturers are applying to the Council on Pharmacy and Chemistry for approval of their preparations.

Do not use, administer or prescribe nonapproved drugs or compounds. Rely upon this safeguard for your patient and yourself.

* * *

You will please your county secretary if you will send your check today for your 1938 county and state dues. Relieve him of the rôle of a dunning collector—he will have more time to devote to other official duties.

* * *

May 9 to 12 is the date, Hotel Huntington in Pasadena is the place for our 1938 annual session. Write today to the manager of the Hotel Huntington for your room reservations. A truly worth while program is about completed. Four very noted guest speakers have accepted invitations to address that session. Commence now to plan to attend.

* * *

Certificates of membership are standard in size. Purchase a frame and display your certificate in your reception or consultation room. Your patients want to know if you are a member of a county society.

* * *

Refer to the front advertising section of each issue for list of state officers, committees, county societies and their presidents, secretaries, and time of meeting each month. While doing so don't fail to read the advertisements and patronize these patrons of your official journal.

* * *

If in doubt as to the coverage contained in your liability insurance policy, the central headquarters office will be glad to review it for you. Your inquiries are welcome. Be sure to read your policy and ascertain if you are adequately protected. Some policies contain many exceptions.

You throw away money if you pay for the listing of your name in any of the so-called special directories. No business will accrue to you from such listing. It is a sales racket for the sole profit of the publisher.

* * *

Read and know—before signing any document or statement.

* * *

One wastes time perusing the items in publications that are sent to you free. They have been well designated as "Throw Away Publications." You do well to throw them away unread and to devote your time reading recognized journals. Most of these free publication articles are calculated to lead you to prescribe nostrums and unapproved remedies that are of little value. Cease being a "capper" for these drug manufacturers. Read and patronize the advertisers of official medical journals. Be wise.

* * *

We are off to a big year—a fine annual session in Pasadena in May, a definite program of postgraduate instruction for each councilor district, a similar program of lay public health education meetings, the annual session of the American Medical Association in San Francisco, and a general election in November with several vital initiatives on the ballot. Of equal importance are the county society regular meeting programs. Medical history will be made in California in 1938.

* * *

In the event of patients complaining of pain in their lower extremities, it is extremely important that your examination eliminate the diagnosis of thromboangiitis obliterans. This point in diagnosis is particularly important before administering electrotherapy treatments or performing any surgical operation on the toes or feet. Failure to observe this precaution may cause you to undergo some untoward experiences.

* * *

"Do you have any doctors around here?" asked a traveler in a remote wilderness region of the Ozarks.

"Hell, no, we don't want no doctors," replied the bewhiskered native, shifting his tobacco from one corner of his mouth to the other.

"What do you do when somebody is sick?" said the traveler.

"We give him a good drink of whisky."

"Suppose that doesn't do him any good; what then?"

"Then we give him another drink."

"And what if that doesn't help him?"

"We naturally give him another."

"And if that doesn't make him better?"

"Stranger, if a man is so sick that three drinks of whisky don't do him no good, then nobody can't do nothing for him."

The above was lifted from the *New York State Journal of Medicine.* Such individuals compose the group, cited by propagandists and economists, that are without medical care. They are not all confined to the Ozarks.

* * *

The Westchester County *Bulletin* states that "doctors spend an average of $820 per year from their income for insurance protection for life, accident, health, malpractice, automobile, public liability, and compensation." This is deemed to be necessary for their financial and business protection.

Yet, when it comes to county medical society membership and the annual dues, the question is raised as to the value and benefits of membership. Your county medical and state medical associations insure and safeguard your practice and professional interests. Insurance of this nature is not purchasable anywhere other than from your county society. Remember this when paying your annual dues.

DRUG-SAMPLE RACKETS

Is your office attendant, secretary, or nurse abetting this racket? Drug manufacturers advertise in good faith their willingness to send you generous samples of their products and leading preparations.

Thousands of dollars of such samples of standard and approved preparations and drugs are sent monthly to physicians answering these advertisements.

Now steps in the racketeer. He calls at your office, usually outside of your office hours and represents to your office attendant that he is a detail agent. He induces your employee to drop a card or coupon to the manufacturers

requesting samples in your name and instructs her to keep them until he returns in ten days or two weeks. In due time he calls, collects the samples and gives to your employee a dollar, a pair of stockings or a box of candy, and departs with the samples.

By such means the racketeer is able to collect unbelievable quantities of expensive drugs and preparations which are, in turn, sold to certain drug stores at greatly reduced prices, yet at a price that yields him handsome financial returns.

Recently a large manufacturer, upon receipt of an unusually large number of requests for samples from a certain locality, sent the samples to its local detail representative, with instructions to deliver in person to the physicians whose purported request had been received. In over 80 per cent of requests, the doctor admitted that he had not sent in for the samples, but recognized the writing of his employee. These employees admitted that they had been induced to send in the request for samples by a person who alleged he was the manufacturer's representative. In another check-up, a different manufacturer uncovered similar methods of the racketeer.

Physicians can and should put an end to this racket and assist in freeing well-intentioned manufacturers from this imposition. This does not mean that you should cease responding to advertisements, because manufacturers are desirous of meeting your requests for samples. It does mean that you instruct your employees to not give away the samples you receive.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Cut-Rate Fees

A certain automobile insurance company has been, and probably still is, endeavoring to secure the services of one or more physicians in different centers to provide medical care for cases in which it is liable. The bait of "sending all cases to one doctor," "exclusive doctor," volume of business is cast to induce the doctor to sign a contract to render these services for fees scheduled at 25 per cent below the present compensation fee schedule. Just why this company should believe it is entitled to cut-rate fees is not evident. Just why a doctor should cut fees is unexplainable as no justification for doing so exists.

We commend and urge each county society to adopt the following resolution of the San Joaquin County Medical Society:

SAN JOAQUIN COUNTY MEDICAL SOCIETY

December 4, 1937.

"That the Board of Directors of the San Joaquin County Medical Society go on record against accepting any cutting of fees or rebating of the same from the existing Industrial Fee Schedule to any Industrial Accident Insurance Company." This action was further amplified at a meeting of the San Joaquin County Medical Society held December 2, 1937, when the following motion was passed. "That the San Joaquin County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the Industrial Accident Insurance Company, that a copy of this resolution be mailed to all members of the San Joaquin County Medical Society and the National Automobile Insurance Company, and that any member accepting work from any insurance company entailing reductions of fees, splitting of fees or rebating of fees be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the committee sees fit."

This action of the Board of Directors of the San Joaquin County Medical Society and of the San Joaquin County Medical Society is called to your attention so that you might govern yourself accordingly.

Yours sincerely,

G. H. ROHRBACHER, M.D.,
Secretary.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

COMPONENT COUNTY MEDICAL SOCIETIES

ALAMEDA COUNTY

The annual meeting of the Alameda County Medical Association was held at Hunter Hall on Monday, November 15, 1937, at 8:15 p. m., President MacLean presiding.

The following program was presented:

1. *Reports on Legislative Matters* by Ben Read. Mr. Read reviewed the proceedings of the last State Legislature.

2. *Progress Notes on Insurance Association of Approved Hospitals* by Dr. Daniel Crosby. Doctor Crosby reminded the Association that our insurance project is just one year old, the charter having been received on November 16, 1936. He outlined progress, quoted statistical data and discussed the problems which are still ahead.

3. *Tuberculin Test in Connection with Part-Pay Patients* by Doctor Bush. The tuberculin tests should be considered important clinical procedure. He pointed out that the Anti-Tuberculosis Association was making every effort to aid the doctors.

4. *Reports of Committees* as follows:

A. *Report of the Publicity Committee:*

A year ago the appointment of the chairman of the Publicity Committee for the Medical Association was made. The president acted wisely in appointing one member of the Association for each of the standardized hospitals in the county. The program which has been adopted and followed throughout the year has taken into consideration two general principles. First, that the publicity appearing in the various newspapers shall be ethical in character and reflect credit and not reflect discredit upon members of the profession or upon the hospital and secondly, to create a cordial relationship between the various newspapers, the hospitals, the physicians in practice and the profession as a whole. This second proposal has been of great importance and opens a wide field that deserves more cultivation.

The Alameda County Medical Association, a number of years ago, discontinued any connection with any publicity bureau or paid publicity man. While this seemed wise at the time, it does seem to me now that if possible some arrangement should be made so that a definite publicity program could be positively carried out in a fashion that would again have for its purpose the publicizing of appropriate cases, matters of interest happening in the professional world, and particularly some attention given to trends in medical practice.

At no time has the public indicated a greater desire than now to learn of medicine and its problems as well as trends looking toward practice and changes in methods of practice.

Not nearly enough has been accomplished during the past year, but at the same time no particular damage has been done. Under an aggressive program of publicity it is believed that much might be accomplished in years to come, should the Association undertake such a program.

Respectfully submitted,

Signed: B. W. BLACK, M. D.,
Chairman, Publicity Committee.

B. *Report of the Library Committee:*

	1936	*1937*
Attendance	1311	1318
Circulation:		
Books	690	814
Periodicals	2171	2203
Total	2861	3017
Reference questions		1119

Attendance and circulation show another slight increase over the previous year. The number of books added from the fund allowed by the Medical Association was forty-two; gifts, five; one subscription was added to the journals, making a total of eighty-three. A contribution of duplicate numbers of journals was made to the Medical Library Exchange, and several journals needed to complete files were received from the Exchange.

Shelf space was becoming crowded and an additional double-faced stack was installed which will take care of the increase for three or four years.

It was decided by the Library Committee to start a collection of reprints of publications of members of the Association, starting with 1930, and a notice was put in the *Bulletin*. Many contributions to the collection have been made, but it is not yet complete. Any members having reprints of which the library does not have a copy, please let us have one.

The librarian attended the annual convention of the State Library Association at Yosemite in May.

The Library Committee again wants to express its appreciation of the careful conscientious work of our Librarian, Miss Kennedy. After all, a working library is not merely a collection of books and journals, but is largely built around the intelligent service of a skilled librarian.

We also want to thank and to commend the many members of the Medical Association, who both personally and by letter, have given to the Library Committee helpful suggestions and constructive criticism.

H. G. Trimble, *Chairman,*
Wallace T. Partch,
Harold Maloney.

C. *Report of the Committee on Public Health:*

The Committee on Public Health has coöperated with the Chamber of Commerce throughout the past year. No items of unusual interest have been encountered.

F. S. Baxter, *Chairman.*

D. *Report of the Milk Commission:*

Personnel:

The Commission continues to operate under the same personnel as last year, namely, Dr. T. C. McCleave, President; Dr. Edith M. Myers, Secretary; Dr. A. Laurence Gleason, Dr. Rexford Hoobler, and Dr. Ira O. Church.

Dr. Charles J. Parshall of the staff of the Department of Animal Husbandry, of the University of California, is the veterinarian in charge of dairy inspection and laboratory examination. Dr. H. H. Darling of the San Francisco Commission continues to be the examining physician of employees of the dairies for both the San Francisco and Alameda County Commission.

Miss Ruth Manning continues in her rôle of secretary to the Commission maintaining the Commission's headquarters in the Ethel Moore Memorial Building, 121 East Eleventh Street, Oakland.

Meetings and Inspection Trips:

Eight meetings have been held during the year. Two additional meetings have been held jointly with the San Francisco Commission. Five inspection trips were made to the dairies by the members of the Commission.

Dr. Edith Meyers was the Commission's representative to the Atlantic City meeting of the American Association of Medical Milk Commissions in June this year.

Dr. Karl Meyer represented both the San Francisco and Alameda County Commissions at a meeting of the California Association of Medical Milk Commissions held in Los Angeles on April 16 of this year, and at a conference of the Committee on Methods and Standards of the National Association of Medical Milk Commissions held in New Orleans.

Dairies:

Two dairies, Meadowlark Dairy at Pleasanton and Burrough Brothers Dairy at Knightsen were certified by the Commission for the first three months of the present year. On April 1, 1937, Burroughs Brothers Dairy withdrew from such certification on account of other more absorbing interests in the milk industry.

Finance:

Collections and disbursements have been handled by the secretary of the Alameda County Medical Association this year, as in the past year. The amount of funds on hand at the present time is $335.11. All bills are paid and all collections are up to date.

Methods and Standards:

Considerable difficulty has been experienced this past year in keeping within the law in the matter of Methods and Standards, as certain revisions made a year ago by a committee made up of eastern representatives could not be applied to our western dairying conditions. This was corrected, however, at the National meeting in Atlantic City.

Dairy Improvements:

Meadowlark Dairy is, at this time, completing a six months' program of rebuilding. In accordance with modern dairy planning, a large new building of reinforced concrete has been constructed. It will house in its various units, a feeding and washing barn, a holding pen and a milking barn; a bottle washing room and bottle storage room, a very large refrigerating room and a bottle filling room. New and modern equipment is being purchased and installed throughout. The plant is a model of a small dairy and to accommodate the many visitors who are drawn by its wide reputation, large plateglass outside windows have been installed in the rooms—all of which are on a level with the ground.

Edith M. Meyers,
Secretary, Milk Commission.

5. *Reports of the Officers:*

A. *Report of the Secretary:*

During the year 1937, twelve regular and one special council meetings have been held. There have been ten regular monthly meetings at which scientific programs were presented. Thirty-five of our own members and one invited guest, Dr. Dudley Smith, furnished the programs.

Twenty-seven applicants were elected to regular membership and two members were received on transfer from component county societies. Thirteen junior associate members were elected to regular membership and one junior associate member was denied regular membership. Thirteen applicants were elected to junior associate membership. Eight regular members and one junior associate member resigned, six were elected to retired membership. Four regular members died, five transferred to component county societies, six were dropped for nonpayment of dues.

Active members, 501. Junior Associate members, twenty-six. Associate members, two. Retired members, twenty-four. Total, 553.

Submitted at the annual meeting, November 15, 1937.

Gertrude Moore, *Secretary.*

B. *The Treasurer* submitted the report of the auditors.

C. *Report of the President:*

Members of the Alameda County Medical Association:

During the year ten regular monthly meetings were held, at which time an attempt was made to present well-balanced programs on common subjects of interest to all but especially to those practicing general medicine. These meetings have been very well attended. There were no special scientific meetings. The suggestion is made that the giving of a prize to the doctor presenting the best clinical paper during the year be considered. Everyone likes to be rewarded for an effort of distinction.

The Council entertained the Secretary of the American Medical Association, Dr. Olin West, at which time a discussion took place concerning the part Oakland will play during the convention of the American Medical Association in 1938. Also, the secretary of the Bureau of Economics of the American Medical Association lunched with members of the Council, at which time various economic problems were discussed.

The first annual "Hobby Show" took place, and it was surprising to see what beautiful work of various sorts was presented by our members. The show was enjoyed by all who saw it. It is hoped that it will be continued at varying intervals in the future.

The annual banquet was well attended and, for the first time in many years, the doctors entertained their ladies. Judging from the spirit of good fellowship and the amount of jollity which was evident, the object of the banquet, which was to promote friendship among members of the profession, was attained.

Throughout the year, the Council has been endeavoring to get the Approved Hospitals of the Eastbay to make it a ruling that no one be allowed to practice medicine within their walls who is not a member of his County Medical Association. If this were done, unethical physicians, and especially those who verge on quackery, would be forced to go to hospitals where their type of medicine would be, undoubtedly, highly appreciated. It is hoped this effort will continue.

Efforts have also been made to develop a Publicity Bureau through which all medical publicity would pass. The newspapers are agreeable to this and have stated that they will not publish anything except criminal publicity con-

cerning doctors if this plan is carried out. A publicity bureau of this type would do the doctor a great deal of good in printing only accurate information concerning medicine and keeping out misinformation and also publicity which smacks of advertising. It is the plan of Council to finish this piece of work.

Inasmuch as this year was one in which legislators met in Sacramento, much time was devoted to the obtaining of proper legislation and to keeping out improper, destructive legislation. A great deal of this work is done through the California State Medical Association but that Association is greatly aided by the Public Health League, in the membership of which Alameda County boasts only about 175. It is surprising the amount of good work the League has been able to do with the small amount of money it has to work with. It is urged that all members of our Association who can, join the Public Health League. It costs $5 per year and is an excellent form of insurance.

Undoubtedly, during the coming year, some various forms of socialized medicine will be pressed for by governmental agencies. In our own county, the Insurance Association of Approved Hospitals has gone steadily forward and has expanded to surrounding counties. This is undoubtedly a step in the right direction, as it still leaves the proper doctor-patient relationship. Aside from this, we all know there is a large group of individuals that do not get adequate care and this is largely a "white-collared" group of people. As time goes along, some scheme may be worked out which will help care adequately for this deserving group of hard working individuals. So far, the various plans of State medicine which have been presented would, without doubt, degenerate into another form of political bureaucracy.

I wish to thank all the members of the Medical Association for the fine coöperation they have given during the past year. H. Gordon MacLean, *President.*

D. *Report of the Board of Tellers:*

Number of ballots cast, 277; number of ballots discarded because of improperly signed envelopes, five; number of ballots discarded because improperly marked, four.

Officers elected:

President, Dr. Clarence DePuy; Vice-President, Dr. Frank Bowles; and Secretary-Treasurer, Dr. Gertrude Moore.

Council:

Rural: Dr. Clifford W. Mack. Oakland: Dr. H. G. MacLean, Dr. Frank Makinson.

Delegates:

Dr. Leonard Barnard, Dr. John Dougherty, Dr. Sumner Everingham, and Dr. H. J. Templeton.

Alternates:

Dr. T. F. Bell, Dr. W. G. Donald, Dr. Fred Ewing, Dr. Lloyd Kindall, Dr. George Nesche, Dr. Robert Peers, Dr. T. Eric Reynolds, Dr. A. C. Siefert, Dr. D. D. Toffelmeir, and Dr. H. G. Trimble. D. M. Allen,
Chairman of Board of Tellers.

Doctor MacLean then presented Dr. Clarence DePuy, newly elected president. Doctor DePuy spoke briefly of his plans for the coming year. The members were reminded of the meeting to be held in San Francisco to hear Dr. Morris Fishbein.

There being no further business, the meeting adjourned.
Gertrude Moore, *Secretary.*

FRESNO COUNTY

The annual meeting of the Society was held on December 7, 1937, at the University Sequoia Club.

The proposition for membership of Dr. H. W. Pasley was announced.

The following were elected members of the Society: Ernst Aronstein, J. F. Bolkovatz, A. C. Pattison, E. R. Schottstaedt, J. A. Thorman, and J. E. Young.

The annual reports of committees were read.

It was moved by Doctor Pettis, seconded by Dr. J. R. Walker, that the Society endorse the antivenereal disease advertising campaign of the Fresno *Bee.* The advertisements are subject to censorship by the Publications Committee, and without financial obligation to members of the Society. The motion was carried.

The following officers for 1938 were elected: Henry Randel, president; Otto Diederich, first vice-president; R. W. Dahlgren, second vice-president; L. R. Nielson, secretary-treasurer; J. M. Frawley, librarian.

Delegates—G. W. Walker, E. J. Schmidt, and R. S. Scott.

Alternates—C. I. Pendergrass, S. A. Quinby, and B. Sorauf.

Board of Directors—J. M. Frawley.

Doctor Anderson spoke on the danger of buying the wrong kind of Lloyds malpractice insurance, of which there are some thirty different kinds. He advised members to consult Hartley Peart, General Counsel of the California Medical Association, before buying.

The scientific program consisted of talks on *Purpura Hemorrhagica* by Dr. Stacy Mettier of San Francisco, and *Acute Gall-Bladder* by Dr. Glenn Bell of San Francisco.
O. B. Doyle, *Secretary.*

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of December 2, 1937, at Eureka Inn, at 6:30 dinner.

The following officers were elected for 1938: Francis Stump, president; L. G. Kramar, vice-president; John A. Lane, treasurer; Lawrence A. Wing, secretary. Delegate, Allan Watson. Alternate, Lane Falk.

The papers of the evening were especially good. Dr. H. Glenn Bell spoke on *Acute Cholecystitis,* and Dr. Stacy Mettier on *Medical Aspects of Arthritis.*

The members enjoyed the visit of our State officers, Dr. Henry Rogers, Councilor, and Dr. Frederick Warnshuis, State Secretary. These officers gave a very excellent report on State Association activities and legislation.

Résumé of meetings for 1937:

President, Allan Watson.

Meetings held, 7; average membership present, 17; visiting speakers, 9; visiting State officers, 2.

After a very enjoyable evening the meeting adjourned.
Lawrence A. Wing, *Secretary.*

KERN COUNTY

The Kern County Medical Society met in regular session at the El Tejon Hotel in Bakersfield on Thursday evening, November 18, Dr. H. R. McAllister presiding. Dr. Lloyd Fox announced plans for the annual banquet to be given on December 18 at the Stockdale Country Club.

The following officers were elected for 1938: President, Dr. Harry W. Lange; Vice-President, Dr. H. A. Rivin of Delano; Secretary, Dr. C. S. Compton; Board of Directors, Dr. Peter J. Cuneo, Dr. L. A. Packard, Dr. Frank J. Gundry; Delegate, Dr. C. S. Compton; Alternate, Dr. Frank J. Gundry.

Because of the widespread interest in the problem of coccidioides infection in the San Joaquin Valley, the Society welcomed the opportunity of hearing Dr. Ernest C. Dickson of Stanford University, who was the speaker of the evening. Doctor Dickson spoke on the *Relation of Coccidoides Infection to "Valley Fever."* He asked the cooperation of the Society in the field study he has undertaken in the San Joaquin Valley. In spite of the great incidence of "valley fever" or so-called erythema nodosum in the Valley, it is only recently that its possible relationship to coccidioides infection has been investigated in Kern County, where a large number of affected patients are seen each year. The Society voted to coöperate with Doctor Dickson in his study in reporting all cases of "valley fever" and especially to aid in the bacteriological studies of sputum from the patients. Dr. Charles E. Smith, associated with Doctor Dickson in this investigation, spoke briefly on the plans and a number of slides illustrating the pulmonary findings in "valley fever" and in clinical coccidioidal granuloma infection were shown.

The meeting was adjourned, following which refreshments were served. C. S. Compton, *Secretary.*

PLACER COUNTY

The Placer County Medical Society held its regular meeting at the Freeman Hotel, Auburn, on December 11, 1937, with the president, Dr. C. E. Lewis, presiding. In addition to President Lewis there were present the following members and visitors:

Members—Doctors Kindopp, L. B. Barnes, Smith, Rood, Lundegaard, Thoren, Hummelt, Atkinson, Vinks, Hirsch, Russell, Peers, and Miller.

Visitors—Doctors Robert Stewart Peers, Herman V. Allington and Thomas I. Buckley, all of Oakland, and Doctor Ward of Auburn.

Following the reading of correspondence, the application of Dr. Edwin Slater Peeke was read for the first time.

Doctors Ray C. Atkinson and Daniel L. Hirsch presented a preliminary report for the Committee on Fee Schedule.

The president then introduced Dr. Thomas I. Buckley of Oakland, who presented a paper on *Urinary Antiseptics* in which he stressed culturing the urine and using mandelic acid therapy for the bacillary group, and sulfanilamid in small doses for the Streptococcus hemolyticus group. He also discussed other urinary antiseptics from their historical as well as their therapeutic efficiency.

Dr. Herman V. Allington of Oakland discussed *Eczematous Eruptions* and illustrated his talk with lantern slides. He pointed out that eczematous eruptions are characterized by red, infiltrated, blistering, weeping, crusting and scaling lesions, and by itching and burning. They may be due to external irritants (dermatitis venenata) or indirectly to internal organic disturbances, ingestion of drugs, and foci of infection. Allergy is an important consideration. In treatment one should first attempt to locate and remove the cause. Local medication should be primarily soothing and protective, with more active and stimulating remedies reserved for the chronic infiltrated forms.

Dr. Robert Stewart Peers, also of Oakland, presented a paper on *The Relation of Gall-Bladder Disease and the Rheumatic Syndrome*. This was a preliminary study of twenty-eight selected cases. These individuals were considered from their type of chronic arthritis and sedimentation tests and gastric complaints and age groups with the roentgenological findings by routine x-ray visualization. An outline of the care of these patients was also suggested.

These very interesting papers evoked considerable discussion.

Following adjournment, refreshments were served.

ROBERT A. PEERS, *Secretary*.

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Raymond Wallerius on October 19, 1937, at the Auditorium on Twenty-ninth and L streets. There were fifty-nine members and guests present.

Doctor Wallerius reported on the case of a forty-year-old woman with osteomyelitis of the tibia, who has been going about town attempting to get morphin.

Speakers of the evening were members of our Society who had attended various clinics and medical congresses, both in the United States and abroad, during the past year.

Dr. O. S. Cook, in his talk, emphasized the method of treating carcinoma of the breast by preoperative x-ray up to 300 r at Adair's Clinic; and the method of doing biopsies by means of a long aspirating needle; the use of radium up to 9,000 milligram hours in the treating of carcinoma of the cervix at the Mayo Brothers Clinic; the treatment of carcinoma of the bladder by means of radium implants used at the Dean and Barringers Urology Clinic; and the treatment of carcinoma of the tongue by means of cones, which fit into the mouth, at the Hays Martin head and neck clinic.

Dr. Ralph Graham spoke on the International Congress of Radiologists at Chicago. The essential points stressed by Doctor Graham were the effect of x-ray on the healing of wounds; the use of x-ray therapy in treating infections, bites, furuncles, carbuncles, cellulitus; and the good results from the use of x-ray in the treatment of lobar pneumonia. The use of x-ray therapy in bronchiectasis and gas-gangrene infections was also suggested.

Doctor Hale told about his experiences and type of work seen at the various European clinics visited; the modern hospitals in London; the use of avertin intravenously by the drop method over a period of hours, as seen at Leningrad, Russia; the use of intravenous diatrast for diagnosis as the only method used in Moscow; and the work on tuberculosis of the kidney as seen in Weilderbold's Clinic in Switzerland. Doctor Hale remarked about the absence of prostatic resections in Europe.

Dr. G. J. Hall spoke on female endocrinology and new hormones, as taken up at the meeting of the Society for the Study of Internal Secretions. Prolactin, a milk forming hormone, and its effect on endometrial hyperplasia was discussed. Doctor Hall stressed the danger in using prolactin for the production of milk because of its action in reducing the function of the ovaries.

Doctor Rulison told of his visit to the International Congress of the Radiologists at Chicago, and was most impressed by the excellent life-size models on diaphragmatic hernia and pictures of the surgery on that type of hernia. Harrington's results on surgical treatment at the Mayo Clinic were discussed, as well as the symptoms found in cases of paraesophageal hernia.

Dr. Hilding R. Johnson showed some excellent motion pictures taken while on his Alaskan trip.

The applications for new membership of Doctors Roscoe Clark, James Yant, Aaron Gourse, Adrian Crossen, and Godfrey Steinert were voted upon and all were elected to membership. The application of Dr. R. O. Schofield for membership by transfer was read for the first time.

Doctor Dozier announced the meeting of the Northern District Medical Society at the Elks Club on November 6.

* * *

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the President Raymond Wallerius on November 16, 1937, at the Auditorium on Twenty-ninth and L streets. There were sixty-three members and guests present.

Dr. L. Taussig of the University of California Medical School presented the first paper of the evening. He discussed *Dermatological Conditions Associated with Diabetes Mellitus*. Doctor Taussig first discussed the relation between the high glucose content of the skin in diabetes and its relation to skin infections. That the amount of sugar in the skin is definitely increased with and increase in blood sugar has been proved experimentally; but there apparently is no proof so far that this causes an increase in susceptibility to skin disease. Doctor Taussig then took up the skin conditions most commonly associated with diabetes, *i. e.*, eczema, chronic urticaria, pruritus, purpura, gangrene, and xanthoma. The roll which diabetes plays in such cutaneous infectious as furunculosis, dermatophytosis, and pruritus, is not known. The paper was concluded by showing lantern slides of some of the cases discussed.

The second paper of the evening was presented by Dr. H. C. Shephardson, who spoke on the *Use of Prolonged Acting Insulins*. Doctor Shephardson opened his discussion by stating that one-half per cent of all the people are afflicted with diabetes, and that one per cent of all the people die of the disease. In comparing the two insulins now in use, it has been found that the maximum effect of regular insulin is attained in three to four hours, whereas the protamin insulin attains its maximum effect in twenty-four hours and acts over a period of seventy-two hours. Protamin insulin has a cumulative effect, and hence the danger of producing a state of hypoglycemia slowly in the patient, with resultant permanent mental changes. This appears to be the main danger in its use. The main contraindications to the use of protamin insulin are (1) infections, such as gangrene and septicemia; (2) treatment of coma. Protamin insulin acts too slow in these cases. Protamin insulin is of the utmost value in children where the number of injections can be cut down greatly, and as a result enables the physician to control these diabetic children without the use of the needle so often. Doctor Shephardson next mentioned the new U80 protamin insulin which is now on the market, and a new crystalline insulin which will soon be available.

The discussion on the papers was opened by Doctor Scatena and continued by Doctors E. Sevier, Frank Lee, and Aaron Gourse.

The application for membership, by transfer, of Dr. R. O. Schofield was read for the second time and voted upon. He was elected to membership unanimously.

Dr. F. F. Gundrum asked that the Society take up the matter of the old minutes of the Society, and stated that he felt these old records should be preserved in a safe place for their historical value. A motion was made and so passed that the officers of the Sacramento Society for Medical Improvement arrange to deposit all such minute books in the State Library in the California section.

Dr. J. B. Harris requested the Board of Directors to take up the matter of a uniform listing of physicians in the telephone directory (classified section).

G. E. Millar, *Secretary.*

SAN BERNARDINO COUNTY

The regular meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, December 7, 1937, at 8 p. m. The meeting was called to order by the president, Dr. D. B. Williams. About sixty members and guests were present.

The application of Dr. Kenneth E. Kellogg of Loma Linda was favorably voted on.

Dr. Lowell Goin, Speaker of the House of Delegates of the California Medical Association, presented facts regarding the medical economic survey made by the California Medical Association some four years ago, and also discussed the *Principles and Proposals* brought about by the *Committee of Four Hundred and Twenty* and stressed a united front by the profession, regardless of an occasional individual's feeling in the matter.

The program of the evening was given as follows: *The Use of Convalescent and Normal Human Serum in the Treatment of Disease* by Dr. Hugh K. Berkley of Los Angeles; *The Convalescent Serum Center and Its Value to the Community* by Dr. C. M. Hyland of Los Angeles.

Informal discussion and questions followed.

The meeting adjourned at 10 p. m., following which refreshments were served.

Arthur E. Varden, *Secretary.*

SAN FRANCISCO COUNTY

The annual report of President T. Henshaw Kelly follows:

The Board of Directors of your Society held its usual regular meetings throughout the year and special meetings on May 24 and September 8, 1937.

During the year, invitations were issued by the Board to the American Medical Association, the American Association of Military Surgeons, and the International Society for Crippled Children, to hold annual meetings in San Francisco. The American Medical Association, as you know, will meet here, beginning June 13, 1938.

The Board considered the matter of blackface type advertising in the telephone directory and requested all members of the county society who indulge in this type of listing in the telephone book to discontinue it, as it is against the policies set up by all principles of ethics.

The matter of speaking before lay groups in other counties by our members was also brought before the Board by the component societies of other counties, who objected to some of the talks thus given. The Board, in justice to other county societies, who cannot control our members, ruled that no member of this Society shall go into another county to talk before a lay group, without receiving the permission of the component county society of the county in which he intends to speak. It has been suggested that a committee be appointed whose duty it shall be to pass upon the fitness of any intended speech by a member to a lay group in the City and County of San Francisco.

Nineteen hundred and thirty-seven saw a biennial meeting of the legislature, and foremost in that session was again the matter of health insurance, activity being along two lines—one by the California Medical Association, designed to permit the physicians of any county to organize and operate a health insurance association; and the other, by existing illegally operating agencies, to legalize themselves and to permit the formation of other loosely organized and supervised agencies. Many of our members gave of their time and effort to further the purposes of the Association, but the legislature adjourned without enacting such legislation.

A move by the Farm Bureau and others to legalize the opening of county hospitals to pay patients was defeated.

The Board approved a bill to prevent untrained and unlicensed laymen from setting up diagnostic and therapeutic x-ray laboratories. This bill was presented to the legislature, passed and pocket-vetoed by the Governor.

On November 30, the Society gave a dinner to Dr. Morris Fishbein, who spoke on the present trends in medical economics in the country. The dinner was attended by 260 members of the San Francisco and other Bay counties societies.

During the year the Society approved a proposed amendment to the Charter designed to remove the office of the Director of Public Health from politics. However, this proposed amendment did not reach the ballot.

It approved the bond issue on the last ballot to provide for improvements at the County Hospital and the Laguna Honda Home, and this was one of the few issues passed by the voters.

Because he is a physician who has devoted himself, as a Supervisor, to assisting medicine and its aims in the City and County government, the Board endorsed the candidacy of Dr. Adolph Schmidt for Supervisor. He was elected.

The Committee on Malpractice Insurance—Doctor Gilman—has done an immense amount of work this year to keep abreast of the changes in malpractice insurance policies which have taken place during the year.

Yearly the coverage and cost of this insurance are decreasing and increasing respectively, and the field has been confused by the appearance of a large number of types of policies written by Lloyd's of London, practically no two of which are alike and many no good. The American companies still writing this insurance have decreased their coverage and increased their costs, and Doctor Gilman is preparing a short report of the present situation, which is to be published in the *Bulletin* either in January or February. Every member should read this and should carefully investigate the actual coverage that his present malpractice policy gives him.

Finally, we come to the matters dealing with the economics of medical practice that have come before the Board during the year.

Previous to 1937, the Shell Oil Company had endeavored to establish a fee schedule and panel of physicians to care for its employees in and about San Francisco. After discussion, argument and distress produced by publication of letters in the *Bulletin,* during this year the Shell Benefit Fund has paid members of this Society for their care of Shell employees and have done so on the basis of their reasonable charges rather than on a panel fee schedule. We hope it will keep on.

The Pacific Employers Insurance Company has recently completed, in conference with a committee of the Board of Directors of your Society, a policy form providing indemnity for medical and hospital costs which is in all ways satisfactory to your Board of Directors. It is indeed an encouraging sign when a company of this standing asks the help and coöperation of the Society in the formulation of such a policy.

The year has seen the establishment of the Insurance Association of Approved Hospitals in San Francisco. As you know, in order that we might have a unified hospital service plan in the Bay region, the San Francisco Society, instead of starting an independent organization, approached this Association in Alameda County and the hospitals in San Francisco County, and an agreement was reached whereby the Insurance Association of Approved Hospitals and nine San Francisco hospitals signed contracts, opened a San Francisco office and began to sell hospitalization insurance policies. Representation of San Francisco medicine and hospitals will be given on the Board of the Approved Hospitals, and the whole project has been worked out harmoniously and effectively. The other Bay region counties have joined in, and the one organization can take contracts for the whole Bay region. The Board appropriated $1,000 to use for promoting the start in San Francisco.

This accomplishment is due, for our part, to the Committee on Health and Hospitalization Insurance, consisting of Drs. Karl L. Schaupp (chairman), J. Marion Read, and Rodney A. Yoell. The Society owes these members its

thanks for their unremitting effort and uncounted hours of time spent in this work and in the other project that came within their purview.

That project is the Health Service of the City Employees of the City and County of San Francisco. As most of you know, this was conceived by the Federation of Municipal Employees, and a proposed amendment to the Charter was presented to the Board of Supervisors in late December for placement on the ballot in the spring election. The terms of this proposed amendment were very objectionable to us and, despite the fact that the Federation's representatives laughed at our committee when it said we would not accept them, we succeeded, with the hospitals, dentists, druggists, grocers, and other interested parties, in so amending the amendment in the Board of Supervisors that it required the Health Service Board, created by the amendment, to provide free choice of physicians, hospitals and other agencies of medical care, and to present, for approval to the Retirement Board any contract or schedule of fees under which it proposed to operate any health service plan.

The Board of Directors of your Society then approved this Charter Amendment. It was passed by the voters, and the city employees then proceeded to elect a Health Service Board under the terms of the Charter Amendment.

This Board then proceeded to dilly dally with our committee for months in an attempt to get from it a fee schedule which it could promulgate as our fee schedule, but the committee refused any schedule except as an integral part of a worked-out plan.

The Health Service Board then signed a contract with the Sutter Hospital group, hired three physicians to make up a fee schedule and then presented these two matters to the Retirement Board for its approval. After four hearings, at which our committee and legal counsel appeared, as well as representatives of the hospitals, nurses, pharmacists, etc., the Retirement Board disapproved both the contract and the fee schedule.

The Health Service Board is now working on some other plan and is to meet with our committee tomorrow night, at which time our committee will present a plan, authorized by the Board of Directors, as a basis for the development of a working agreement. What the outcome of this will be, we do not know. We are anxious to work with the Health Service Board, for whatever develops from this Amendment will doubtless be a pattern for other communities, and we should like to develop a plan that will provide the best of care without undermining the basic tenets of medical practice. So far, coöperation has not been the outstanding characteristic of the Health Service Board, or at least, of some of its members.

It has been a busy year. In practically my last words as president I want to thank you all for my office. I have enjoyed it and hope that I have justified the choice.

More do I want to thank those who worked with me, pleasantly and so faithfully, to carry out those things which presented themselves for doing. T. Henshaw Kelly.

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SAN JOAQUIN COUNTY

The annual meeting of the San Joaquin County Medical Society was held on December 2 in the Walnut Room of the Hotel Clark. The meeting was called to order by President John Blinn. A very excellent dinner was served.

The petition of Dr. H. E. Schwing of Standard, California, was read and referred to the Admissions Committee.

The annual report of the secretary-treasurer was read and approved. It was moved by Dr. D. Powell, seconded from the floor, that the secretary-treasurer be given a vote of thanks for the splendid work done in 1937. The motion was carried.

Dr. C. A. Broaddus read a report of the Postgraduate Committee.

There was considerable discussion from the floor concerning the attempts of the National Automobile Insurance Company to have practitioners in this county rebate 25 per cent of their fees to this company. It was moved by Doctor Van Meter that the San Joaquin County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the National Automobile Insurance Company; that a copy of this resolution be mailed to all members of the San Joaquin County Medical Society and the National Automobile Insurance Company; and that any member accepting work from any insurance company entailing reduction of fees, splitting of fees, or rebating of fees, be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the Committee sees fit." This was seconded by Dr. C. V. Thompson. The motion passed.

The following are the results of the election, reported by the Elections Committee:

A. C. Boehmer, president; N. P. Barbour, first vice-president; F. A. McGuire, second vice-president; G. H. Rohrbacher, secretary-treasurer.

Directors—G. H. Sanderson, H. C. Chapman, C. V. Thompson, C. A. Broaddus, J. F. Blinn, D. Powell, and J. F. Doughty.

Delegates—D. Powell, G. H. Sanderson, and J. F. Doughty.

Alternates—C. A. Broaddus, G. H. Rohrbacher, and C. V. Thompson.

The paper of the evening was presented by Dr. Phillip King Brown of San Francisco, who spoke on *These Changing Times in Medicine: With an Interpretation of Some Observations on Medical Practice in Mexico.*

There being no further business to come before the Society, the meeting was adjourned at 10:45 p. m.

G. H. Rohrbacher, *Secretary.*

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SHASTA COUNTY

The Shasta County Medical Society had its last meeting at the Hotel Redding on November 15, 1937. The meeting was called to order by President O. J. Hansen.

The fact that there were three cultist practitioners recently arrived in Redding for the purpose of practicing, and the fact that they were allowed to practice surgery and medicine in the St. Caroline Sanitarium, caused the following motion to be brought up and passed:

"That the Shasta County Medical Society go on record to discountenance the aiding, abetting, assisting, or employing any person who professes to practice a system of treatment of the sick other than regularly licensed doctors of medicine, graduates of approved medical schools, by any member of the Shasta County Medical Society. Any member violating this rule will be expelled from the Society in accordance to his agreement in entering the Society."

Members present were: Doctors Hansen, Seeley, Olberg, Pratt, Kay, and Dozier. Guests were: Doctors Murphy and Falk. Leslie J. Seeley, *Secretary.*

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SOLANO COUNTY

A regular annual meeting of the Solano County Medical Society was held at the Casa de Vallejo Hotel at 8:30 p.m. December 14, 1937, the meeting being called to order by President Perkins.

A motion was passed that members of the Society prescribe no drugs except those accepted by the American Medical Association, and that California and Western Medicine be requested to print a list of new and nonofficial remedies periodically. Motion carried unanimously.

The secretary was instructed to write a letter to Senator Hiram Johnson and one to Congressman Buck, urging them to vote for a revision of the Pure Food and Drug Act which would shortly be introduced in Congress. The secretary was instructed to sign the names of all members of the Society to this letter.

The secretary asked the older members whether they could remember seeing a charter for the County Medical Society at any time during the Society's history. Doctor Peterson and Doctor Leachman, who were the oldest members present, could remember no charter having been presented to the Society. A Constitution Committee is to be appointed by the incoming president to revise our present Constitution.

Dr. Johann Couperous of Rio Vista was accepted as a member of the Society by unanimous vote.

A motion was made by Doctor Parks and seconded by Doctor Finan that meals reserved at our monthly dinners which are not cancelled before the meeting shall be billed to the member making the reservation. Unanimously carried.

Election of officers resulted as follows: Dr. Ream S. Leachman, Vallejo, President; Dr. Milford Bransford, Vallejo, Vice-President; Dr. John W. Green, Vallejo, Secretary-Treasurer; Delegate, Dr. John W. Green; and Alternate, Dr. D. B. Park.

The same Board of Censors will continue to serve until a new Constitution is presented and approved.

A report was made by the secretary on the address made by Dr. Morris Fishbein, Secretary of the American Medical Association, which was delivered at San Francisco at the Palace Hotel on the evening of November 30.

The secretary also discussed the final report of the California Medico-Economic Survey, stressing certain points made in the informal comments concerning possible interpretations and conclusions to be drawn from the factual data, and also commended the good sense of the Official Committee on Publication consisting of Dr. Howard Morrow, Dr. Edward Pallette, and Dr. George Kress.

The Society was once more invited to become more familiar with California and Western Medicine.

The Committee on Post-graduate Study, Dr. A. V. Doran, Chairman, and the committee which was appointed to meet with the women's clubs, were discharged with thanks for past services.

The secretary discussed the recent study made by the Solano County Institutions Committee, appointed by the supervisors with a view to better medical service for our indigents without increased costs to the taxpayers, and suggested that a revolving staff for the County Hospital to serve without pay might be an advisable step.

Proposals for medical defense were then taken up and applications for membership in the Medical Society of the State of California were presented to each member and they were encouraged to remit $10 to the Society for legal defense in case of suits for malpractice. It was also brought out that a policy written by Lloyd's of London was available through the firm of Newhouse & Sayer which supplied indemnity of from $50,000 to $150,000 for approximately $55 per year. Attention was also called to the fact, that because there were many so-called "Lloyd's Policies," some with and others with less merit, that before signing up, it was advisable to write to the central office of the California Medical Association for further information.

John W. Green, *Secretary.*

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, November 9, 1937.

Members present were: Doctors Hendricks, Coffey, C. A. Smolt, Shore, Mosher, Bardill, Drace, Gronhovd, Barker, and Morrison. Guests were: Doctors Pressman, Hirchfield, Kuffel, Garrett, Moore, and Witten.

Dr. J. J. Pressman of Los Angeles presented moving pictures of the larynx and vocal cords in normal and pathologic states. The members present expressed great interest in these pictures.

It was decided that the December meeting would be given over to the annual election of officers.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County

David Hadden

Los Angeles County

Alfred Fellows — Monte Salvin
Stuart C. Knox

Riverside County

Lawrence H. Hall — Hudson H. Martin

Sacramento County

Aaron Gourse

San Diego County

Gilbert F. Harris — Kerwin W. Kinard

San Francisco County

John E. Bohm, Jr. — William M. Fitzhugh
Adena C. Dutton — George Bernhard Miller

Shasta County

Morton J. Murphy

Yolo-Colusa-Glenn County

Albert R. Egan — Hugh M. Simmons
Lloyd R. Hennig — Max A. Waters

Transferred (4)

W. H. Barnes, from Alameda County to Butte County.

Elmer M. Bingham, from Riverside County to Yolo-Colusa-Glenn County.

John B. Hollingsworth, from Yolo-Colusa-Glenn County to Alameda County.

Richard O. Schofield, from Placer County to Sacramento County.

In Memoriam

Fehliman, William Edward. Died at Portland, Oregon, November 25, 1937, age 57. Graduate of Rush Medical College, University of Chicago, 1906. Licensed in California in 1919. Doctor Fehliman was a member of the Santa Cruz County Medical Society, the California Medical Association, and the American Medical Association.

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Hull, Leonard Charles. Died at Hollister, November 26, 1937, age 67. Graduate of Cooper Medical College, San Francisco, 1893. Licensed in California in 1894. Doctor Hull was a member of the San Benito County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Rea, Thomas. Died at Yreka, December 1, 1937, age 57. Graduate of Oakland College of Medicine and Surgery, 1913, and licensed in California the same year. Doctor Rea was a member of the Siskiyou County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Styan, William Earnshaw. Died at San Francisco, November 24, 1937, age 63. Graduate of the College of Physicians and Surgeons, San Francisco, 1906. Licensed in California in 1909. Doctor Styan was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Wall, Albert Samuel. Died at Los Angeles, September 9, 1937, age 76. Graduate of Miami Medical College, Cincinnati, Ohio, 1890. Licensed in California in 1917. Doctor Wall was a retired member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

OBITUARY

William Edward Fehliman

1879–1937

A motor accident while returning to his home from his favorite recreation, elk hunting, caused the death of Dr. William E. Fehliman, one of the best known and loved of Santa Cruz physicians, on November 24, 1937.

William E. Fehliman was born near Sedan, Indiana, on September 16, 1879. His family soon moved to Nebraska and his boyhood was in that state. After an academic course at the University of Chicago a medical career was begun at Rush Medical College, from which he was graduated in 1906. Following an internship at Cook County Hospital, Doctor Fehliman entered practice at Lead, South Dakota, and continued at that place until entering the

service of his country in 1917. While in Lead Doctor Fehliman was married to Lola Inez Shackelford, who now survives. From 1917 to 1919 Doctor Fehliman served as captain in the Army Medical Corps, being attached to the New York 77th Division, the greater portion of his army career being at the front in France.

Following the war, Doctor Fehliman came to Santa Cruz in 1917 and associated himself with Dr. Stanley W. Dowling in the practice of medicine. During his years of practice in Santa Cruz Doctor Fehliman gained the respect and confidence of the community. His ability and tireless efforts in the behalf of those in need were appreciated not only by his patients, but also by those who knew him only as a friend. His untimely passing is a distinct loss to the community of Santa Cruz.

Doctor Fehliman was a member of the Santa Cruz County, California, and American Medical Associations.

SAMUEL B. RANDALL, M.D.

✝

John Randolph Haynes

1853–1937

October 30, 1937, recorded the death of Dr. John Randolph Haynes, age 84.

Doctor Haynes was born at Fairmont Springs, Pennsylvania, June 13, 1853; he received his M.D. degree from the Medical School of the University of Pennsylvania in 1874. Was in private practice in Philadelphia until the year 1887, at which time he came to California.

Two years later he became a member of the faculty of the then College of Medicine of the University of Southern California, as associate professor of gynecology .

Some years ago Doctor Haynes practically retired from private practice.

In CALIFORNIA AND WESTERN MEDICINE of July, 1937, on page 37, appeared a photograph of Doctor Haynes and a brief article containing newspaper excerpts made on the occasion of his eighty-fourth birthday.

From the Los Angeles *Examiner:*

Dr. John R. Haynes, the "grand old man of municipal ownership" in Los Angeles, blew out the candles on his birthday cake in the quiet parlor of his Figueroa Street home yesterday and settled back in his chair to talk of his fifty years in the city and of things to come in the next fifty years.

He was eighty-four years old. During the last half-century, as a liberal whose faith would not fail, he had served his city, his state, and his country; his creed, democracy, and his cause, municipal ownership. Since 1921 he had served as a member of the Water and Power Commission. . . .

The achievement Doctor Haynes finds most pride in was the writing into the California Constitution of the initiative, referendum, and recall, California being the first state to adopt these measures, which were considered ultra-liberal at the time of their proposal.

The Los Angeles *Herald-Express,* in an article concerning Doctor Haynes, reported as follows:

Bequeathing the bulk of his estate to the cause of promoting the well-being of mankind, particularly the working people, the will of Dr. John R. Haynes, civic leader, philanthropist and president of the Los Angeles Water and Power Commission, was filed on October 15.

This humanitarian work, the will provides, shall be carried out through the trustees of the John Randolph Haynes and Dora Haynes Foundation, which was created by Doctor Haynes and his wife in September, 1926.

While Doctor Haynes had been reputed to be a millionaire, it was stated that in recent years he and his late wife, Dora Haynes, had given away large sums for charitable purposes and that the property remaining probably would amount to less than a million dollars, but more than $500,000. Doctor Haynes died last Saturday at the age of eighty-four.

After a number of bequests to relatives, the will bequeathed the residue to the Foundation. This residue, with large endowments made by Doctor Haynes and Mrs. Haynes since its organization, will give the Foundation a working capital of approximately one million dollars, it was reported today.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS President
MRS. FRED ZUMWALT Chairman on Publicity

News Letter

Dear Auxiliary Members:—The holidays are now over and I hope that, for each and all of you, they were pleasant ones. You will be delighted to know that when Christmas gifts were being distributed the Auxiliary was not forgotten. *A present of two new counties!* That is what your State Chairman of Membership and Organization, Mrs. Frederick N. Scatena of Sacramento, has given to you. These two counties are Butte and Santa Cruz, and they are splendid and welcome additions to a splendid organization. With the acquisition of these counties we now have all (those that are more thickly populated) of the larger counties organized. This is a very fine record for the short period that the Auxiliary has been in existence in the State of California—eight years, to be exact. But let us not be satisfied until *every county* is organized and *every woman* who is eligible a member.

Both of these recently formed counties have already sent in reports of their organization meetings. They are printed just below in this issue; be sure to read them. Personally, I wish to thank them for their prompt coöperation.

The goal of our president when she took office was a 100 per cent membership, and some of the counties are helping her to attain it. Mrs. Rogers' own Auxiliary, Alameda County, has taken in over thirty-two new members in less than two months. Los Angeles County has signed up, in one month's time, sixty-one new members! And "lest we forget," Marin County has a membership of thirty-seven and there are but thirty-nine eligible women in the county.

If any of the other counties have reports of this kind to give, please send them in, for "nothing succeeds like success."

Sincerely yours,

MRS. FRED H. ZUMWALT.

Component County Auxiliaries

Alameda County

Members of the Alameda County Auxiliary met on Friday, November 19, 1937, at luncheon in the dining room of the Claremont Country Club. The meeting that followed was in the Lounge. As usual, an informal half-hour of reception, presided over by Mrs. George Reinle, preceded the affair. Reservations were in charge of Mrs. O. T. McAllister.

Reports of board members' activities were given at the business meeting, at which the president, Mrs. A. A. Alexander, presided. Mrs. Harold Trimble, state chairman of *Hygeia,* in an interesting and stimulating talk, told of this publication of the American Medical Association and urged each member to see that it be placed in at least one home this Christmas. Mrs. W. H. Sargent, past president of both the Alameda County and California State Auxiliaries, also spoke on the value of *Hygeia,* and then gave a short report of the work done by the Auxiliary's Battalion in the Community Chest drive. We were proud to hear that our workers had gone over the 100 per cent mark set for us.

Dr. Benjamin Black, Director of Alameda County Institutions, was the honored guest. His subject was relative to his work as a public health director. As he is one of

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt, and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

our most popular and delightful speakers, the attendance was large; many expressed the wish that we have the privilege of hearing Doctor Black more often.

The next meeting of the Auxiliary will be held at the Claremont Country Club in January, at which time a very fine program of both medical and cultural interest will be presented.

Our membership now totals 292! We are happy to welcome the following members: Mesdames E. W. Page, T. C. McCleve, Hewitt Robinson, J. T. Harkness, Erwin Epstein, Fred Fisher, Gale Whiting, W. W. Nicholson, Floyd Lewis, W. E. Hart, R. G. Libby, R. J. Walker, Ronald W. Troup, W. S. Williams, E. J. Jakemy, C. E. Cocks, Don Manley, P. H. Miles, and E. M. Grimmer.

Mrs. Grant Ellis,
Chairman of Publicity.

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Butte County

Wives of the members of the Butte County Medical Society met on Tuesday, November 9, 1937, relative to forming a Woman's Auxiliary.

Mrs. Frederick N. Scatena of Sacramento, First Vice-President of the State Auxiliary and State Chairman of Membership and Organization, was the guest of honor and gave an interesting talk, telling of the need and value of the Auxiliary organization throughout the state and nation. She spoke of the success and organization history of her own county, Sacramento.

After the address by Mrs. Scatena, a short business meeting was held at which initial plans of organization were formed and the following officers elected: Mrs. J. H. White of Chico, president; Mrs. W. H. Barnes of Chico, vice-president; Mrs. J. H. Alexander of Chico, secretary; Mrs. L. A. Jacoby of Oroville, treasurer. The directors are: Mesdames N. T. Enloe, C. C. Landis, J. H. Fabrian, and J. G. Hepplewhite.

At the conclusion of the meeting, tea was served.

Mrs. J. H. White,
President.

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Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met for luncheon on November 23, 1937, at the County Medical building, Mrs. Eliot Alden presiding.

A group of songs was rendered by Miss Martha Friedberger. Mrs. Robert Heffner gave a most interesting talk on her work as referee at the Juvenile Hall. Medical highlights were presented by Mrs. Karl von Hagen.

The Philanthropy Committee, in charge of Mrs. Harold E. Crowe, had asked for contributions of canned food for the Thanksgiving baskets, and they were collected at this meeting. This committee functions at holiday seasons, distributing staple foods, fruit, candies, and magazines to the families of a few needy doctors in the county.

Mrs. Robert L. Carroll,
Corresponding Secretary.

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Marin County

A very enjoyable luncheon meeting was held on Thursday, November 18, 1937, at the Alta Mira Hotel in Sausalito. There were twenty-one present.

Mrs. Furlong announced that there was a contest on for *Hygeia*. It was decided that the Auxiliary should have a card party to raise funds for subscriptions to *Hygeia*. Mrs. G. Landrock was appointed committee chairman. Her committee members are Mesdames Marston, Miller, Hawkins, and Robinson.

Mesdames Polland, Hazeltine, Fowler, Robertson, and Conroy were appointed as a new committee to determine the philanthropic work of the Auxiliary.

Mrs. Hobart Rogers, State President, and our first guest speaker, was then introduced. Mrs. Rogers gave us a brief and inspiring talk on the purpose and ideals of the organization. She mentioned the many things that it had accomplished and the hopes that she had for its future.

Mrs. Charles Hall, State Corresponding Secretary, then thanked Marin County for its coöperation and urged us to keep up the good work.

Miss Edith Waterman, Chairman of the Red Cross in San Rafael, was then introduced and told of the numerous services the Red Cross had rendered during the year. She suggested that the Auxiliary might assist the Red Cross in establishing emergency stations along the highways, or it might help in maintaining a list of registered donors to be called for immediate blood transfusions. Sending wheelchairs and hospital beds would be a great help. She also suggested that assistance in the development of the Braille program for the blind was needed.

There was no further business and the meeting was adjourned.

Mrs. R. B. Hartman,
Chairman of Publicity.

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Riverside County

The November meeting of the Woman's Auxiliary to the Riverside County Medical Society was held at the home of Mrs. C. N. Callander, with Mrs. Ratliff and Mrs. Wayland Coon as cohostesses.

Dr. and Mrs. Olsen of San Bernardino presented a program, descriptive of their recent European tour. This was illustrated with motion pictures. Mrs. Erwin Miller told of a trailer trip taken during the summer, and Mrs. Arthur W. Walker described vividly a visit she had made to the famous "quints."

The members seem most enthusiastic, and we expect to have an enjoyable and profitable year.

Katharine L. Wickman,
Corresponding Secretary.

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Sacramento County

About forty members of the Woman's Auxiliary to the Sacramento Society for Medical Improvement met at the home of Mrs. E. O. Brown on Tuesday evening, November 16, 1937.

Mrs. Donald R. Benson gave several vocal selections, accompanied by Mrs. Zue Geary Pease. Bridge occupied the remainder of the evening. A buffet supper was served.

Joining Mrs. Brown as hostesses were: Mesdames Albert Almada, Harry Baird, H. H. Beauchamp, W. H. Davis, Walter Hicks, Frank Krull, and D. L. McLean.

Mrs. Hugh Carmichael,
Chairman of Publicity.

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Santa Cruz County

Our first meeting—the organization meeting—of the Woman's Auxiliary to the Santa Cruz Medical Society was held at the home of Mrs. Alfred L. Phillips on Thursday, November 18, 1937.

Mrs. F. N. Scatena of Sacramento was guest speaker, and told us of the purposes and advantages of the Woman's Auxiliary.

The following officers were elected: Mrs. Alfred L. Phillips, president; Mrs. H. G. Watters, first vice-president; Mrs. N. R. Sullivan, second vice-president; Mrs. Gordon Bunney, corresponding secretary; Mrs. R. C. Alsberge, recording secretary; Mrs. W. E. Fehliman, treasurer. The directors are: Mesdames A. N. Nittler, to be in charge of programs; O. C. Marshall, to be in charge of the educational work that is to be planned; J. D. Fuller, who will be responsible for the work at the County Hospital; Mrs. D. S. Woodward will act as hostess.

Our regular meetings will be held on the second Monday of each month at the Rio Del Mar Country Club.

Mrs. R. C. Alsberge,
Chairman of Publicity.

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San Diego County

The Woman's Auxiliary to the County Medical Society was particularly favored on Tuesday, November 9, 1937, in being permitted to view a portion of Dr. George Huff's

colored films taken during his recent trip abroad. His illustrated lecture, entitled *Russian Medicine*, emphasized the very drab, delapidated, and rundown conditions of buildings and equipment in Russia.

Doctor Huff illustrated very clearly the low standard of living, the impoverished appearance of all people in the Russian streets, the lack of transportation facilities, the hopeless, dejected expressions of the old and young alike. He showed many street scenes in which automobiles were a rarity. Only officials possess cars in Russia. One doctor, who had rendered great service, was permitted an automobile with two chauffeurs. His use of the car usually included about thirty miles a week, every movement and call being carefully reported by the chauffeurs to the government. The doctor was not permitted to use the car for personal pleasure at any time.

Doctor Huff called attention to the need for doctors in Russia. The Soviet Government is now giving the medical students a salary while attending school.

He states that medical work in Russia is organized under various departments. The obstetrical department is headed by a most remarkable woman. Stalin recently sent an order to her, stating: "Eliminate venereal diseases." This was a large order, but the doctor ordered treatment for every infected person, and a legal statute has made it a criminal offense, punishable by not less than eight years in prison, for any person to transmit the disease. Prostitutes are examined every two weeks. Venereal diseases have not been eliminated, but great material progress has been made.

The equipment of all hospitals in Russia is extremely poor. The nurses are poorly dressed, with no stockings whatever. The rooms look bare and badly in need of repair.

However, in the field of obstetrics, Russia has made some remarkable progress. In other countries of Europe, midwives deliver many of the babies, but in Russia it is a law that all babies must be born in the hospital, and doctors are legally responsible for getting their patients to the hospital in time for delivery. The mothers are cared for and given pay during pregnancy and for a certain period after the birth of the child.

After visiting clinics all over Europe, Doctor Huff states that he believes America to be far ahead of all European countries in the field of medicine.

On December 14, Mrs. E. A. Blondin presented a book review to the Auxiliary.

On November 20, the annual dinner dance of the Auxiliary was enjoyed at the U. S. Grant Hotel in the Plata Real. It proved to be a most enjoyable occasion.

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San Francisco County

Honoring our state president, Mrs. Hobart Rogers, members of the Woman's Auxiliary to the San Francisco County Medical Society and guests gathered at a formal tea on Monday, November 29, 1937, at headquarters, 2180 Washington Street.

Presiding at the tea table were Mesdames Thomas Gibson and Julius Sherman, assisted by Mesdames J. V. Leonard and Lewis Michelson. Among the state officers who attended were Mesdames Harry C. Hund, Harold Trimble, and Charles C. Hall. Auxiliary presidents of neighboring counties were Mesdames A. A. Alexander of Alameda and Thomas Gocher of Marin.

Decorations for the tea table and rooms, in autumn foliage, fruits and vegetables, were beautifully arranged by Mrs. John D. Humber. A travel film of Mexico was shown at 2:30, preceding the tea.

Mrs. A. S. Musante, Chairman of Arrangements, was assisted by Mesdames George H. Becker, Anthony B. Diepenbrock, Howard B. Dixon, Arno G. Folte, John D. Humber, Otto Laist, Edmund J. Morrissey, William W. Newman, Harry R. Oliver, Frank Rodin, and Stuart C. Way. Members of the receiving line were: Mesdames Hobart Rogers, Fred H. Zumwalt, A. S. Musante, Harry C. Hund, William Sargent, and Thomas J. Clark, Jr. Our president, Mrs. Hans Barkan, was absent on account of illness.

Mrs. Rogers made an official visit to the Auxiliary at the regular meeting on November 16, at which time she gave a most inspiring talk. The purposes of our organization were clearly outlined, and the importance of the membership supporting the county, state, and national auxiliaries emphasized.

As guest speaker for the November meeting, Dr. Harold K. Faber delivered an interesting address on the *Recent Advances in Our Knowledge of the Treatment of Infantile Paralysis*. For the general meeting on Tuesday, January 18, Dr. Mary H. Layman will honor the Auxiliary with a discussion on the *Effect of Motion Pictures on Children*.

Plans are being formed for an Auxiliary dinner in February for members and their husbands. Mrs. Thomas Gibson and Mrs. George H. Becker will be chairmen of arrangements.

Mrs. Harry R. Oliver,
Chairman of Publicity.

Basle Nomenclature in Anatomy.—The BNA (Basle nomina anatomica) is the product of the Commission on Nomenclature appointed by the Anatomical Society in 1889. Its report (the BNA) was accepted in 1895 at a meeting in Basle, Switzerland.

This society was international; in 1895 it had 145 German members and 129 members from other nations. The chairman of the commission was Prof. W. Krause of Berlin; the members included Prof. G. D. Thane of London, and representatives of several other countries were invited to join it. They were among the ablest anatomists of that time.

The need for it appeared in the multiplication of terms. More than 30,000 were in the literature for 4,500 structures. Wilder, Gould and Gage in America, Henle in Germany, and the anatomic societies of Germany, Britain and America had urged the necessity of simplification.

The commission served without pay. The cost of correspondence and mimeographing was about $3,000; it was defrayed by scientific academies of Germany and Austria Hungary and by the Anatomical Society.

The plan included only names of descriptive gross human anatomic structures. Personal names were omitted except as some few had become universally adopted and firmly established as to make their omission impossible—these were added in brackets. The governing principles were as follows:

1. Each part shall have only one name.
2. It shall be in Latin, philologically correct. (Most names were in Latin form anyway and Latin is the only international language.)
3. It shall be short and simple.
4. It need not be descriptive nor speculative.
5. Related terms shall be similar.
6. Adjectives shall, in general, be arranged as opposites, as major-minor; superficialis-profundus.

More minute terms used in the medical specialties were omitted.

The work was admirably done. More than five-sixths of names previously used locally were abandoned—they were not necessary. The arrangement of terms indicated the normal structure—branches of vessels, nerves and others. The use of these names in the atlases of Spalteholz, Toldt, and Sobotta and in the textbooks of all countries led to its adoption almost universally, to the great advantage of medical sciences and of medical students.

The International Association of Anatomists, established later, has continued the revision. It has now a Commission on Nomenclature, including several American members; Professor Jackson of Minnesota is chairman of the American section. The commission has suggested a few changes and is now considering others.

Types of Pneumococci in Sputum of Patients with Pneumonia.—Of the 192 strains from the sputum of patients with croupous or bronchial pneumonia out of 300 type-identified strains of pneumococci tabulated by Nissen, the predominating types were I, present in 35.9 per cent, VII in 10.4, III in 9.4, VI in 7.3, IV in 5.2, and VIII in 4.7 per cent. In rubiginous sputum from eighty-three patients, pneumococcus types I, VII, IV, and III were most frequent; type-specific agglutinins in the blood were established with rising and falling titer in the cases in which types I, IV, and VII appeared in the sputum.—*Ugeskrift for Laeger.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

* * *

American Academy of Orthopedic Surgeons, Los Angeles, January 16–20, 1938. Carl E. Badgley, M.D., 1313 East Ann Street, Ann Arbor, Michigan, Secretary.

Pacific Coast Surgical Association, Los Angeles, February 22–25, 1938. H. Glenn Bell, M.D., University of California Hospital, San Francisco, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of January is as follows:

Saturday, January 1—Holiday (New Year's).

Thursday, January 6—KECA, 11:00 a. m., The Road to Health.

Saturday, January 8—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 13—KECA, 11:00 a. m., The Road to Health.

Saturday, January 15—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 20—KECA, 11:00 a. m., The Road to Health.

Saturday, January 22—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 27—KECA, 11:00 a. m., The Road to Health.

Saturday, January 29—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Decoration Bestowed upon Dr. J. C. Geiger.—The following letter refers to an honor recently bestowed upon Dr. J. C. Geiger, Director of Public Health, City and County of San Francisco:

(COPY)

CONSULADO DE CHILI

San Francisco, California,
December 6, 1937.

My dear Doctor Geiger:

It gives me great honor to inform you that I have just received a letter from the President of the Chilean Delegation to the Orient, the Honorable Senator Maximiano Errazuriz, in which he asked me to advise you that the Government of Chili has granted to you the decoration, "Cruz de Caballero de la Orden del Merito," for your good friendship and assistance to my country and for your excellent work in and outstanding contributions to public health.

The diploma and insignia will be sent in the near future.

As representative of Chili, I wish to extend to you my sincere congratulations for this public recognition by my Government.

Very sincerely,

(Signed) MARIO ILANES,
Consul of Chili.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Trichinosis.—An outbreak, involving twenty cases of trichinosis, was investigated during October by the State Board of Public Health. They were found on the route of a peddler who sells delicatessen meats. The source of infection was in improperly processed smoked ham, which came from a small establishment.

The American Board of Internal Medicine: Written Examination.—The American Board of Internal Medicine will hold its next written examination on Monday, February 14, 1938, in various centers of the United States and Canada.

The examination will consist of two sessions of three hours each, with the morning session held at nine o'clock and the afternoon session held at two o'clock.

The candidates who are successful in this written examination will be eligible to take the practical examination which will be held in San Francisco the Friday and Saturday prior to the opening of the annual session of the American Medical Association in June, 1938.

The final date for filing applications for this written examination is January 15, 1938, and all applications should be in the office of the chairman before that date.

For further particulars and application blanks, please address Walter L. Bierring, M.D., Chairman, American Board of Internal Medicine, Suite 1210, 406 Sixth Avenue, Des Moines, Iowa.

Los Angeles Heart Association.—The sixth annual symposium on heart disease was held in Los Angeles on December 16 and 17, 1937. The program is given below:

Thursday, December 16

8 p. m.

(Joint Meeting with Los Angeles Clinical and Pathological Society)

Social Aspects of Heart Disease—John C. Ruddock, M.D.

The Surgical Treatment of Hypertension—Arthur L. Bloomfield, M.D., and David A. Rytand, M.D.

(By Invitation)

Friday, December 17

Morning Session, 9:45 a. m.

Diuretics—William Paul Thompson, M.D.

The Heart in Relation to Asthma and Emphysema—J. J. Singer, M.D.

The Management of Children with Rheumatic Heart Disease—Louis E. Martin, M.D.

The Heart in Hyperthyroidism—Phillip Corr, M.D.

Digitalis—Norman F. Crane, M.D.

Influence of Improper Diets upon the Heart—William Boeck, M.D.

Friday, December 17

Afternoon Session, 2 p. m.

Cardiac Care after Decompensation—R. Manning Clarke, M.D.

Heart Disease in Relation to Anesthesia and Surgery—J. F. Anderson, M.D.

Roentgenographic Methods in Cardiovascular Diagnosis—Wilbur Bailey, M.D.

Pericarditis—A. M. Roberts, M.D.

The Cardiac Neuroses—Verne Mason, M.D.

Errors in Cardiac Diagnosis—Louis E. Viko, M.D.

(By Invitation)

Evening Session, 8 p. m.

President's Address—William H. Leake, M.D.

The Use of Electrical Amplification in the Interpretation and Analysis of Heart and Lung Sounds—Louis E. Viko, M.D.

(By Invitation)

Collections of electrocardiograms, roentgenograms, and pathological specimens will be exhibited during the Friday sessions. E. Richmond Ware, M.D., William H. Leake, M.D., Ernest M. Hall, M.D., John W. Budd, M.D.

Into the Medical Corps of the Navy: Examination for Entrance.—An examination of candidates for appointment as lieutenant (junior grade) in the Medical Corps of the Navy will be held at all naval hospitals in the United States and at the Naval Medical School, Washington, D. C., beginning May 16, 1938.

Candidates for admission must be between the ages of twenty-one and thirty-two years at time of appointment, graduates of Class "A" medical schools, and have completed an internship of one year in a hospital accredited for interns by the American Medical Association and the American College of Surgeons.

Those who are interested should write the Surgeon-General, United States Navy, Bureau of Medicine and Surgery, Navy Department, Washington, D. C., for further information in regard to the examination and the procedure to follow for them to appear before one of the examining boards.

American Public Health Association.—The officers of the American Public Health Association (address, 50 West Fiftieth Street, New York, N. Y.), announce that the sixty-seventh annual meeting will be held in Kansas City, Missouri, October 25-28, 1938.

Dr. Edwin Henry Schorer, Director of the Kansas City Health Department, has been appointed chairman of the local committee. He will be assisted by a large group of city and state officials and community leaders.

A long list of affiliated organizations meet habitually with the American Public Health Association. They include: The American Association of School Physicians; the Association of Women in Public Health; the Conference of State Laboratory Directors; the Conference of State Sanitary Engineers; the American Association of State Registration Executives; Delta Omega; and the International Society of Medical Health Officers.

The attendance at the sixty-seventh annual meeting will exceed three thousand professional public health workers from every state in the Union, Canada, Cuba, and Mexico.

Grant Gives Big Impetus to Cancer Work at the University of California.—The means for greatly increasing the production of radio-active substances for the treatment of cancer and other diseases, and greatly decreasing the cost of such substances, has been placed in the hands of the University of California through a grant of $30,000 by the National Advisory Cancer Council of Washington, D. C. The grant has been made directly to Dr. E. O. Lawrence, professor of physics and head of the University of California's Radiation Laboratory, and comes on the eve of the removal of the laboratory to new and larger quarters on the campus.

The grant, according to Doctor Lawrence, will be applied to increasing the output of the new cyclotron, which is to be installed in the new laboratory early next year. The present cyclotron has already produced some two hundred radio-active substances, such as radio-sodium, radio-phosphorus, and radio-iron, and these will be applied to medical problems in the new laboratory. The new cyclotron is accordingly being called the "medical cyclotron."

The Radiation Laboratory already has produced radio-active substances equal in temporary radio-activity to one gram of radium. These amounts have been found adequate for hospital experimental use and at the present time can be produced at a cost comparable with that of radium. As the cyclotron is in the very earliest stages of technical development, Doctor Lawrence expresses the belief that its efficiency can be greatly improved, and it can be made to produce the equivalent of ten grams or more of radium at a consequent reduction in cost of manufacture of the radio-active substances. The fund from the National Advisory Cancer Council was given Doctor Lawrence in order that the radio-active substances may be made more cheaply and more abundantly and that they may cover the greatest possible ground in biological experimentation and application. Perhaps the most important feature of the newly created substances is that they are nontoxic, and may be taken into the digestive tract or administered intravenously without harmful consequences. They also permit a close observation of their action on the blood and the body otherwise through the "tagging" of atomic content through radio-active properties.

Los Angeles Surgical Society.—The annual meeting of the Los Angeles Surgical Society was held on Friday and Saturday, December 10 and 11, 1937, with headquarters in the Los Angeles County Medical Association Building. The program of the meeting follows:

Friday, December 10

9 a. m.

Dry Surgical Clinic, Los Angeles County Hospital

John F. Erdmann, M.D., New York

Guest Speaker

Bone Malignancies—Paul E. McMaster, M.D.

Gastroscopic (Demonstration)—John F. Renshaw, M.D. (By invitation.)

12:30 p. m.

Luncheon—County Medical Building

1925 Wilshire Boulevard

2 p. m.

Some Important Points in Aseptic Intestinal Resection—Foster Collins, M.D.

Operative Treatment of Dislocated Peroneal Tendons (slides)—Ellis Jones, M.D.

Immediate Repair of Divided Nerves and Tendons of the Hand (motion picture)—John E. Kirkpatrick, M.D.

Hour-Glass Tumor of the Spinal Cord—Mark Glaser, M.D.

Volvulus of the Cecum—E. Eric Larson, M.D.

Cancer of the Rectum with Complications—William Daniel, M.D.

Some Cases of Bone Tumor— A. E. Gallant, M.D.

Recess Ten Minutes

Hemorrhagic Cysts of the Kidney—A. J. Scholl, M.D.

An Evaluation of Common Anesthetic Methods—Arthur E. Guedel, M.D. (By invitation.)

Treatment of Hemorrhoids by the Injection Method—William Kiger, M.D.

Chronic Subdural Hematoma as a Problem in the Differential Diagnosis of Intracranial Lesions—Leo J. Adelstein, M.D.

Acute Perforation of Gastrojejunal Ulcer—Harold Thompson, M.D.

Regional Ileitis—Joseph Jellen, M.D. (By invitation.)

Retrotracheal Intrathoracic Toxic Adenoma of the Thyroid—Verne C. Hunt, M.D.

Annual Dinner, 7 p. m.

Saturday, December 11

9 a. m.

Dry Surgical Clinic, Los Angeles County Hospital

John F. Erdmann, M.D.

Malignancies of the Lower Urinary Tract—H. C. Bumpus, M.D.

Demonstration of Peritoneoscope—John Ruddock, M.D. (By invitation.)

12:30 p. m.

Luncheon—County Medical Building

1925 Wilshire Boulevard

2 p. m.

A Critical Analysis of One Thousand Cases of Appendicitis—E. C. Moore, M.D.

Recent Advance in the Treatment of Head Injuries—Carl Rand, M.D.

Solitary Paratyphoid Lesion of the Large Bowel—Wayland Morrison, M.D.

Injection Treatment of Hernia—William Weber, M.D.

Fatalities in Hernia Injection—Clarence J. Berne, M.D.

A Ruptured Appendix That Spontaneously Drained Through the Internal Abdominal Ring and Down the Canal of Nuck—Burns Chaffee, M.D.

Treatment of Urinary Extravasation (with motion picture)—Carl Rusche, M.D.

Recess Ten Minutes

Carcino-Osteogenic Sarcoma of the Chest Wall with Five-Year Follow-Up (with slides)—Frank Breslin, M.D.

Treatment of Occlusive Vascular Diseases — Vernon Thompson, M.D. (By invitation.)

Surgery of the Elderly Patient—J. N. Nichols, M.D.

Postoperative Complications, 1234 Cases—L. A. Alesen, M.D.

The Problem of Testicular Malignancy—Franklin Farman, M.D.

The Administration of Sulfanilamid—Albert Bower, M.D. (By invitation).

Reconstruction of a Mutilated Face Resulting from Automobile Accident (motion picture)—Arthur E. Smith, M.D.

American Board of Obstetrics and Gynecology: Examinations.—The next examination (written and review of case histories) for Group B candidates who have filed applications will be held in various cities of the United States and Canada on Saturday, February 5, 1938.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Applications for admission to the June, 1938 Group A examinations must be on an official application form and filed in the secretary's office before April 1, 1938.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Poor Health and Worry Insignificant at State University.—Poor health, worry about self or family, failure to make friends, emotional upset and other factors that are usually held responsible for improper adjustment of the University student to his surroundings and his studies, appear to be comparatively insignificant at the University of California. Intensive studies of the adjustment problem, made by Dr. Merton E. Hill, director of admissions, on one thousand transfers from junior colleges, show that the problem is far less concerned with the personal make-up of the student, as it is with outside influences, such as the time taken for self-support, and insufficient funds.

But 1.1 per cent of the group examined found their studies and activities hindered by poor health. None could be found who lacked medical care. Worry about home or family interfered with the school work of but 1.3 per cent. Failure to make friends concerned only 0.6 per cent, while the lack of student activities concerned only 0.4 per cent.

Emotional upset, which is supposed to cause many young people to quit school, claimed but 2.4 per cent of the group examined. Slow reading habits hindered 4.0 per cent, while living arrangements affected the work of 3.6 per cent.

The college course which causes the most difficulty appears to be economics. Chemistry comes next, but such supposedly "tough" subjects as astronomy, bacteriology, and biochemistry proved a stumbling-block for less than ten students for each of these subjects, out of the 905 who were questioned concerning them. The proportions are made more even, however, by reason of the fact that there are a great many more students taking economics than the other subjects.

Annual Expenditures of California State Board of Public Health.—On page 174 of the "Formal Report on Factual Data" of the California Medical Economic Survey is printed a table (Appendix G-13) that does not indicate how funds are allocated. Each county receives from the State $3 per week per patient to aid counties in the care of tuberculous citizens, as given in the first column of the table below. The administration expense of the State Board of Health, as expended through funds allocated by the legislature, is given in the fourth column (Total Administrative Expense).

	Total Tuberculosis Subsidies Paid	Total Administrative Expense[1]	Total Administrative Expense[2]
1920-1921	$106,721.13	$244,158.11	$255,863.72
1921-1922	150,456.92	290,372.31	305,099.12
1922-1923	156,612.36	303,764.35	318,179.98
1923-1924	176,755.71	184,697.10	193,021.46
1924-1925	214,429.23	216,415.41	224,871.98
1925-1926	235,117.97	225,556.64	276,540.22
1926-1927	257,312.76	262,528.37	334,154.65
1927-1928	287,697.27	260,338.93	344,826.07
1928-1929	237,119.09	288,930.92	384,753.26
1929-1930	378,876.73	292,951.82	404,582.96
1930-1931	440,255.79	326,417.01	458,051.69
1931-1932	482,259.59	304,987.45	402,908.07
1932-1933	519,726.50	284,783.71	372,138.50
1933-1934	550,785.68	201,847.65	304,318.44
1934-1935	562,116.51	208,547.56	325,671.61
1935-1936	589,151.85	226,257.36	388,697.83
1936-1937	304,573.32	255,951.11	500,310.28

[1] Exclusive of subsidy and exclusive of self-supporting activities and of those without legislative appropriation.

[2] Exclusive of the subsidy and special funds, but inclusive of cannery inspection and nurses' registration.

Dental Conferences.—The dental staff of the Bureau of Child Hygiene of the California State Board of Public Health is now composed of three dentists and a dental hygienist. They have worked in eleven counties, holding forty-one conferences, have instructed 1,868 children on the care of the teeth, and have examined the teeth of 357 children. In addition, 565 dental operations have been performed on seventy-one children. These activities during the month of October were carried on in Trinity, Modoc, Lassen, Alpine, and Mono counties. During the month, dental unit Number One, a fully equipped trailer, was exhibited before the Twelfth District Dental Society at Alturas.

Epidemiology.—In the new handbook of public health bacteriology issued under the auspices of the San Francisco Department of Public Health, Dr. J. C. Geiger, Director of that department, contributes an introductory chapter on epidemiology which is of interest. He states:

"Two modern weapons of public health work are bacteriology and epidemiology. Many of our older and sometimes successful health officials regard them as synonymous. As a matter of fact, lemology or lemography, meaning the sum of human knowledge as to pestilence, was known long before the science of bacteriology came into existence. The term "epidemiology" and its corresponding branch of the science of medicine, public health, are comparatively more actively used today and oftentimes the application to suitable problems is quite misunderstood, accordingly. Where disease affects the individual, the problem becomes that of the physician. Should this disease be of a communicable nature, like influenza, the locality, the city, the state, the nation, or the world may be involved.

On the other hand, diseases that are not communicable, such as those of the heart, but which may have some definite and perhaps controllable feature that can be applied to the population as a whole, can well come within the scope of epidemiological study. Likewise, the effect of disease on groups selected by age, sex, environment, climatic changes, occupation, even emotional and religious factors, may play their part. Therefore, epidemiology is a science with many ramifications, giving graphic or word pictures of the occurrence, incidence, distribution, the infectivity, the virulence of the causative microbic or viric factor, and the seasonal or calendar periodicity, both present and past, of communicable diseases."

A Human Death from Rabies.—A veterinarian residing in Los Angeles County was called July 19, 1937, to treat a small dog for suspected arsenic poisoning. While administering an antidote to the dog, he was bitten on both thumbs. The dog's teeth sank into the nail on one thumb and it was necessary to pry the dog's jaws apart in order to release the thumb. The animal died the following day and the head was taken to a laboratory, where an examination for rabies proved positive. The Pasteur treatment was administered within twenty-four hours to the veterinarian, who had been bitten by the animal. Iodin or some other antiseptic had been used on both wounds, but there was a delay of twenty-four hours in the cauterization with fuming nitric acid, which is the only proper agent to use for the purpose.

The Pasteur treatment of fourteen doses was completed uneventfully. About October 12 or 13, approximately ten weeks after completing the treatment, the patient suffered from headache, pain in hand and arm, was unable to sleep. On the following days he became progressively worse, ate with difficulty, unable to swallow, suffered from spasms upon attempting to drink, became irrational, requiring restraint, and died October 18, 1937.

The antirabies serum was manufactured by a reliable firm and had been kept under proper refrigeration. It would seem probable that the cauterization was late and did not destroy the virus under the thumb-nail. The Pasteur treatment is ineffective in a very small proportion of cases, and there is a possibility that this case fell in such a group. At all events, this unfortunate disaster emphasizes the fact that rabies is epidemic in California and that similar cases, tragic as they are, must be expected to occur until such time as the disease in animals, particularly dogs, may be brought under control.

University Has Important Data on Child Growth.—The data obtained by the Institute of Child Welfare of the University of California on different aspects of growth and development of children, cannot be duplicated elsewhere in the world. The utilization of this data is expected to develop a considerable reorganization in the techniques of teacher training in this State.

These conclusions have been reached by Dr. Daniel A. Prescott, member of the education faculty of Rutgers University, who is completing a year's study of both child and adolescent training in the University of California, under a special fellowship of the General Education Board, New York. The Board, which is actually a foundation maintained by Rockefeller funds, supports a number of the research activities of the institute.

Doctor Prescott listed twenty-three studies made by the Institute in the ten years of its existence, many of which concern aspects of growth and development in the same individual. The data range from biochemical tests and sociological findings to playtime behavior and samples of art produced by children of various ages. Not only will these studies figure in future teacher training, but they have many implications for the curricula of the secondary schools, Doctor Prescott said.

"These studies concern the problem of what the educators should know about children if they are to deal with them effectively," Doctor Prescott said. "The proper handling of the energy output, moods and emotions and the amount of work the pupil should do in the schoolroom and at home, are vitally concerned with these studies. The relation of physical growth to the child's social status is given attention, also.

"The task undertaken by the institute is a tremendous one, calling for a great deal of research."

Fourth Annual Postgraduate Assembly: Alumni Association, College of Medical Evangelists.—On Sunday, December 5, 1937, the Alumni Association of the College of Medical Evangelists presented the following program:

Morning Session

9:00 a. m.—Newer Developments in the Treatment of Arthritis, Dr. Robert Alan Hicks, Clinical Associate and Director of Laboratories, The Wyatt Clinic, Tucson.

9:30 a. m.—Treatment of Compound Fractures, Dr. Walter Ehalt, Chief Assistant Boehler Fracture Clinic of Vienna and Lecturer American Medical Association of Vienna.

10:00 a. m.—Contact Dermatitis, Dr. Laurence R. Taussig, Assistant Clinical Professor of Dermatology, University of California School of Medicine, San Francisco.

10:30 a.m.—Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis, Dr. Edward W. Hayes, Associate Professor of Tuberculosis, College of Medical Evangelists School of Medicine, Los Angeles.

Recess

11:15 a. m.—Abdominal Surgery in Children, Dr. Loren R. Chandler, Associate Professor of Surgery and Dean of Stanford University School of Medicine, San Francisco.

11:45 a. m.—Certain Intraspinal Lesions as a Cause of Sciatica, Dr. Howard C. Naffziger, Professor of Surgery, University of California School of Medicine, San Francisco.

12:15 p. m.—The Present Status of Convalescent Serum Therapy, Dr. Clarence M. Hyland, Pathologist, Children's Hospital, Hollywood.

Afternoon Session

1:45 p. m.—Some Things the General Practitioner Should Know About the Eye, Dr. William A. Boyce, Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles.

2:30 p. m.—Treatment of Superficial Malignancies, Dr. Henry J. Ullmann, Director, Department of Cancer Research, Santa Barbara Cottage Hospital, Santa Barbara.

3:00 p. m.—Management of Vomiting in Children, Dr. Clifford D. Sweet, Chairman of Section on Pediatrics of American Medical Association.

3:30 p.m.—X-ray Treatment of Chronic Inflammatory Processes, Dr. Frederick Rodenbaugh, Director of the Radiological Departments, Franklin and Mary's Help Hospitals, San Francisco.

Recess

4:15 p. m.—Food Poisoning, Dr. Jacob Geiger, Department of Health, City and County of San Francisco.

4:45 p.m.—Medicine and Social Security, Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association.*

5:15 p.m.—Painful Feet, Dr. Ernst Freund, Associate Professor of Orthopedics, College of Medical Evangelists School of Medicine, Los Angeles.

Evening Session

7:00 p. m.—Consideration of Rectal Diseases in General Practice, Dr. Malcolm R. Hill, Associate Professor of Proctology, College of Medical Evangelists School of Medicine, Los Angeles.

7:30 p. m.—The Treatment of Angina Pectoris, Dr. William Paul Thompson, Assistant Professor of Medicine, College of Medical Evangelists School of Medicine, Los Angeles.

8:00 p.m.—Urology in Children, Dr. A. Elmer Belt, Associate Professor of Urology, College of Medical Evangelists School of Medicine, Los Angeles.

8:30 p.m.—Acute Mechanical Obstruction of the Bowel, Dr. William B. Holden, Professor of Clinical Surgery, University of Oregon School of Medicine, Portland, Oregon.

Press Clippings.—Some news clippings dealing with matters related to public health activities or medical practice follow:

Doctors Quit Hospital as "Politics" Hit

Visiting Staff of San Luis Obispo Institution Demands a Complete Reorganization

San Luis Obispo, Dec. 16.—Resignation of physicians, surgeons, and dentists in San Luis Obispo County from service on the visiting staff of the County General Hospital was in the hands of the Board of Supervisors today.

The alternative to the wholesale resignation was, according to the hospital's visiting staff, a complete reorganization of hospital management, removing it from "political control" and placing it in the hands of the staff.

Doctors, surgeons, and dentists continued their hospital work today, but it was generally admitted that the formal filing of the resignations had brought to a head a long-continued dispute over hospital management.

One regular and one resident physician in San Luis Obispo and one regular physician in Paso Robles were unaffected by the resignation. The members of the visiting staff who resigned have been assisting the regular physicians.

Meeting Monday

The next meeting of the Supervisors is set for Monday.

Pointing out in the letter, signed by E. D. Anderson, secretary of the visiting staff, and by every member of the County Medical and Dental Associations, that "we stand ready to give our services to the County Hospital, provided that institution is operated for genuinely indigent patients and free from political influence," the doctors charge that "many patients have been admitted regardless of ability to pay."

This, they assert, places an unfair burden upon the taxpayers, who bear the cost of maintaining the hospital.—*Los Angeles Examiner,* December 17, 1937.

* * *

Doctors, Dentists Boycott Hospital, Accuse Politicians

San Luis Obispo, Dec. 17. (UP).—The County Hospital was under "boycott" today by the entire San Luis Obispo County medical and dental professions.

Doctors and dentists informed the County Supervisors they would no longer act on the visiting staff. They termed the hospital a "political football," claiming that county officials' friends, well able to pay for services, are being treated free. The two groups demanded a special welfare department to examine the financial condition of all hospital applicants.—*Los Angeles Examiner.*

* * *

Three New Regents

Los Angeles can be proud of the high type of citizen represented by the three choices for members of the Board of Regents of the University of California, as named by Governor Merriam. The filling of all three vacancies from this section was to equalize the Board geographically.

Eleanor Banning Macfarland, as a member of one of the Southland's oldest and most influential families, the Bannings, is intimately familiar with the fundamental problems of higher education. She, herself, took special courses at the University of California. As secretary of the English-Speaking Union and an authority on League of Nations work, she has a broad outlook on social problems of the day.

Stuart O'Melveny as head of the Title Insurance and Trust Company has proved his business acumen and keen discernment. He is the son of Henry W. O'Melveny, the pioneer attorney, and is himself a native of Santa Monica. His training is expected to be invaluable in helping to meet economic problems of the University.

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Gratifying to this area, too, is the choice of young Fred Moyer Jordan, the first graduate of the University of California at Los Angeles to be named to the Board. Jordan is only twelve years out of college, but he has become widely popular in alumni circles. He is head of the U. C. L. A. Alumni Association at present.

The Governor is to be congratulated upon his choices. They are ably qualified to help guide the destinies of one of the world's greatest universities.—Editorial, *Los Angeles Times,* December 26, 1937.

* * *

Federal Control of Medicine Might Be Dangerous Plan

Federal control of medicine may have just been indorsed by 430 physicians in the East, but it is unlikely that it ever will be favored by a majority of the 164,000 other doctors who make up the profession in the United States.

Medical discovery and mechanical progress are the only two things that lift us above the level of the ancient races. In government and the arts we are no better than were the Greeks and Romans, perhaps not so good. And the willingness of modern people for war certainly is no advance from the age of stone or bronze.

Only in the conquest of disease have we exhibited any ascendant humanity or altruism. The discoveries of Harvey, Lister, Pasteur, and hundreds of other unsung heroes—and heroines—of medical research were highly individualistic.

Nationalization of medicine could only serve to dull personal effort and tangle a noble occupation in a maze of petty politics in which studious and sincere doctors would find themselves subordinated to less-meritorious handshakers. Nationalization, it might be said here, is merely the modern sugar-coated word for socialization—whether of medicine, railroads or electric power—and twenty-five years ago was branded Red Socialism.

With all doctors working for the Government, and dependent for advancement on political favor, the average citizen probably would have to call up the ward boss to get attention for a sick child in the middle of the night.

Soldiers are particularly aware of what happens under the regimentation of medicine. Army medical officers become unusually calloused to human ills.

It is only human nature. Every soldier on sick call is a suspected malingerer. Soldiers with pride will not report to the infirmary until they are ready to drop.

"Paint it with iodin and mark him 'Duty,' " is an Army sarcasm, purporting to be the usual order of the surgeon to the medical orderly, regardless of whether the applicant has appendicitis or a broken leg.

Attendants at governmental institutions, prisons especially, charge that an inmate must be at the point of death before he can get any treatment other than a dose of salts.

Those examples are possibly an indication of what civil medicine could become if a uniformed service reduced physicians—good and mediocre—to a common rank. Getting in line for attention at a medical clinic, even federal, or getting in line for anything—except a theater—is too European for the American taste.

Of course, federal control has more adherents than those 450 who recently endorsed it. Among this group were 125 from the remote country districts of the New England states. Doubtless, it is a struggle for a physician to maintain himself in thinly populated and impoverished areas. It might be possible for the Government to provide physicians so situated, East or West, with a subsidy, making up the difference between a fair income and what the doctor can collect from his patients, thus providing proper attention for the people of farms and villages.

People now living have seen more medical discoveries than were made in the preceding 2,300 years which spanned known medical history back to Hippocrates, the Greek father of medicine, whose oath to aid the sick without thought of self is still taken by every graduating surgeon today. Nearly all keep it.

Our present system, the trusted family physician with his recourse to specialists in emergency, could not be shackled without damaging the welfare of the people. Public medicine is necessary to a certain extent—but not to 100 per cent.

For instance, no Americans who can possibly pay, want machine-like and impersonal obstetrics for their families.

Perhaps, if many of us were as meticulous with the doctor's bill as we are with the rent and car payment, there wouldn't be any talk of federal control of medicine.—*Los Angeles News,* November 30, 1937.

* * *

Legislation Demanded

Washington.—W. G. Campbell, Food and Drug Administrator here, has demanded legislation empowering the Federal Government to prevent the marketing of dangerous drug mixtures, such as the sulfanilamide "elixir," before they have taken their deadly toll.

Supplementing his report on the activities of the Administration for the fiscal year ending June 30, 1937, he stated in an interview that the $200 fine for first offenses against the Food and Drug Act was "no deterrent at all" to a manufacturer.

Speaking specifically of the "elixir," responsible for scores of deaths throughout the United States because the sulfanilamide, hailed by doctors as a major medical advance, was mixed with diethylene glycol, a dangerous chemical, Mr. Campbell asserted that the manufacturer should have made it his business to learn that diethylene glycol was dangerous before he used it. He added that the Federal Government should have the power to see that drug manufacturers do not make "mistakes" like that one again.

* * *

Health Clinic Merger Urged

Consolidation of county and all municipal health organizations under one county-wide department of health was urged yesterday by Dr. Robert E. Plunkett of New York, nationally known health authority. He recently completed an exhaustive survey here in conjunction with the county's Bureau of Research.

Doctor Plunkett, who is general superintendent of tuberculosis hospitals for the State of New York, also recommended early construction of two 500-bed tuberculosis hospitals, with selection of patients to be under the direction of the County Health Commissioner.

Citing figures that tuberculosis mortality in the United States has fallen since 1900 from 202 persons per 100,000 population to fifty-five persons last year, Doctor Plunkett advised enlargement of clinic activities and unified nursing programs to maintain the advances.—*Los Angeles Examiner,* December 1, 1937.

* * *

Supervisors Urge New State Laws for Nonresident Relief

The Board of Supervisors today was on record as endorsing a drive seeking new state legislation which would extend relief to so-called "technical nonresidents" of Los Angeles County, following demands presented by the Workers' Alliance.

Three hundred members of the alliance jammed the board's assembly room yesterday to request an amendment of present state laws prohibiting relief for persons who have not been self-supporting in California for at least three years, one of them in the county where application for aid is made.

The board also ordered investigation of complaints against present administration policies of the county charities department after members of the workers' delegation voiced claims that hundreds of Los Angeles school children whose parents are on relief are suffering from malnutrition.—*Los Angeles Herald-Express,* December 7, 1937.

* * *

Rift Over Government Aid

New York, Dec. 1.—The split between the American Medical Association and the committee of 430 prominent physicians, of which Dr. Russell L. Cecil of New York Hospital is chairman, appeared appreciably widened yesterday, following a statement which Prof. John P. Peters of Yale University School of Medicine, handed out in reply to the attack the association's official journal made to the committee's four "principles" and nine "proposals" for changes in medical practice. Some of these would entail government support of certain aspects of materia medica.

The committee holds that "the health of the people is a direct concern of the government," whereas the American Medical Association view, voiced by its journal, is strongly against the proposals, holding that the government should not be permitted to influence, through money grants, medical practices or hospitalization.

Professor Peters, who is secretary of the committee, in a statement made public during the week-end, revealed for the first time that the program of his body had been presented to President Roosevelt by a small group of physicians and that the President had "listened graciously and sympathetically," but had made no commitments.

To Continue Campaign

Doctor Peters at the same time made it clear that his committee would continue its campaign to "liberalize" the American Medical Association and challenged the stand by the association's journal that no member of the association should support the committee's program. He denied that the association had rejected the committee's proposals, adding that should this happen, it would still be the "privilege" and, indeed, the "duty," of members of the committee to try by every reasonable means within their power to influence not only the governing body, but all the component societies and individual members to join them in a purpose they consider "good and just." . . .

* * *

Medic Alumni Will Banquet

More than 120 alumni of the medical school of the University of Southern California will gather tomorrow night

in the banquet room of the Los Angeles County Medical Association for their annual reunion.

Dr. H. B. Tebbetts, president of the alumni, will preside. Dr. Rufus B. von KleinSmid, president of the university, and Dr. Frank F. Barham, an alumnus, who is publisher of The Evening Herald and Express, will address the physicians.

Other Speakers

Dean Paul McKibbon of the Medical School, and Dr. George Kress, president of the Los Angeles County Medical Association, also will speak.

At the conclusion of the dinner, officers for the forthcoming year will be installed. Dr. Harold R. Witherbee, vice-president, will succeed Doctor Tebbetts. His place will be filled by Dr. Pierre Viole, present secretary-treasurer, who, in turn, will be succeeded by Dr. Anthony Lauber-sheimer.—*Los Angeles Examiner,* December 17, 1937.

* * *

Los Angeles Called No. 1 Quack Nest of United States

Up to State to Run Medical Charlatans Out of City, Dr. Morris Fishbein Declares

Los Angeles is America's No. 1 quack nest!

This was the declaration of Dr. Morris Fishbein, editor of the American Association Journal, yesterday when he addressed the fourth annual postgraduate assembly of the College of Medical Evangelists.

"It is high time state officials were driving the quacks out of business in Los Angeles," he said. "I have been in every city in the United States at least five times in the last two years, and I say without reservation that Los Angeles has more quacks than any other place in the country.

"This city is full of medical charlatans and numbo-jumbo practitioners of all kinds. It is up to the state of California to clean up the town!"

Ruin Many Lives

Doctor Fishbein declared medical quacks are ruining the lives of hundreds of persons every year.

"These fakirs with their lurid promises of cure-alls are bringing sorrow and tragedy to many of our citizens," he said. "I urge the men and women of the medical profession to join in the fight to end widespread quackery in Los Angeles."

Doctor Fishbein addressed one thousand physicians and surgeons in Paulson Hall of White Memorial Hospital.

Other speakers included Dr. Jacob Geiger of the San Francisco Department of Public Health, and Dr. Walter Ehalt, lecturer for the American Medical Association of Vienna.—*Los Angeles Examiner,* December 5, 1937.

* * *

Insulin Shock Saves Mind

Oklahoman's Mental Faculties Restored as Christmas Gift

Vinita (Okla.), Dec. 22. (AP).—A 29-year-old oil-field worker went home from the State Hospital today with a priceless Christmas gift—a clear, sound mind.

Doctors said he had been rescued from insanity by "shocks" of insulin.

Dr. Felix M. Adams, superintendent, explained that the patient, an inmate for five years, was the second dementia praecox cure out of an original group of eight started on the insulin treatment by the hospital last August.

Reaction Gratifies

"It is grand the way they react," he said. "They all improve physically at first.

"Two others, one a college graduate who majored in mathematics, the other a farm boy, could not answer questions coherently a few weeks ago. Now they organize their thoughts and express them lucidly. They are going home for a while. Though not quite normal, they may not have to come back.

"And this other young fellow who is going home for Christmas with his mother and sister, why, he's tickled to death, and as grateful. What a priceless Christmas gift for the family!"

Others to Get Care

A new group of twenty-five patients will be started on the insulin treatment soon. Even with the results so far, Doctor Adams believes a record for the insulin method has been set here. Previous experiments in Europe and the United States had been limited to dementia praecox cases of two years' duration.—*Los Angeles Times.*

* * *

California Clinics to Spread New Health Methods

San Francisco, Dec. 18.—To insure that the developments of medical science may be carried from one end of the state to the other as quickly as they issue from the clinics and laboratories of the central medical centers, the California Medical Association has launched a five-year plan of field demonstration and study clinics. Nine cities—Stockton, Fresno, Riverside, San Bernardino, San Diego, Santa Barbara, San Jose, Santa Rosa, and Sacramento—have been suggested for the first of the clinics, and other cities will be added as the plan develops.

The plan, which has been titled "A Five-Year Study Program for Graduates in Medicine," links the medical centers of the Universities of California, Stanford, and Southern California, and the College of Medical Evangelists in Los Angeles, in the effort to establish numerous other centers strategically, and thereby assure a simultaneous spread throughout the state of the very latest procedures and developments in the healing sciences. Under the plan physicians and surgeons in the remotest places, who have found it difficult to take advantage of the consultation facilities provided by the large centers, may now go to the nearest clinic center and take advantage of those facilities to the fullest degree.

The clinics will be conducted by faculty members from the four centers named. In addition, the committee in charge contemplates forming teams of clinicians who will conduct a series of conferences in key centers in northern California.

In its preliminary announcement the Association states that the plan has been devised to enable the practitioner in the field to remain abreast of scientific progress, and to apply to his practice the newer procedures without delay, no matter how far he may be from the originating source.

The field clinics are the outgrowth of a partial field demonstration plan tried out by the University of California Medical School two years ago.—*Los Angeles Herald-Express.*

* * *

Asserts Pacific Coast Smuggling of Dope Drops

Washington, Dec. 18. (AP). — Intensive war against smugglers, waged by the enforcement unit of the Customs Bureau, has virtually stopped importation of illegal narcotics on the Pacific Coast.

E. G. Shamhart, chief of the unit, said today no narcotics smuggled from the Orient had been seized on the west coast in months, while that which had been captured was found to have been smuggled through New York and shipped to coast peddlers.

Shamhart attributed the decrease of the smuggling on the Pacific to the expanded enforcement unit which circled the coasts and borders of the nation, with customs agents trained in the work of trapping smugglers. He said the ship strike on the West Coast and the war in the Far East had put the finishing touches to the criminals. . . .

LETTERS

Concerning American Red Cross: A letter of appreciation.

The American Red Cross
National Headquarters

Washington, D. C.,
December 1, 1937.

To the Editor:—Please allow me to express to you in behalf of our national officers our very sincere appreciation for the generous contribution of space which you gave to the American Red Cross in California and Western Medicine. It is only through the splendid coöperation which you and others give to us each November that we are enabled to extend a universal invitation to all Americans everywhere to participate in Red Cross work through individual memberships.

Cordially yours,
(Signed) Douglas Griesemer,
Director of Roll Call.

Concerning the California Heart Association.

California Heart Association
for the Study and Prevention of Heart Disease

San Francisco,
October 15, 1937.

To the Editor:—The California Heart Association is now pushing forward the program which has been carefully worked out by the leading medical authorities of the State. These activities will be of greatest importance and will have a direct effect upon every practicing physician in California.

This program correlates and enlarges the work which has been carried on for the last ten years by the Los Angeles Heart Association in Southern California and

the work of the San Francisco Heart Committee in the northern part of the State.

Dr. W. P. Shepard of San Francisco heads a committee of physicians, attorneys, and industrial leaders, who have addressed themselves to the problem of heart disease in industry. The answer to specific questions is being sought by four well-organized subcommittees.

Under the leadership of Dr. Wilton L. Halverson of Pasadena, detailed studies have been outlined to obtain all possible specific knowledge about rheumatic fever in California.

The Executive Committee of the Association has been working in conjunction with the California Medical Association's standing Committee on Postgraduate Activities for many months. Within a short time a five-year course of instruction in all branches of heart and circulatory diseases will be offered to all doctors of the State.

Continuing the work of past years, a two-day symposium on heart disease was held in San Francisco, November 17 and 18; and another in Los Angeles, December 2 and 3. Each year these meetings add notable contributions to our knowledge of heart and circulatory diseases.

The California Heart Association has made a promising beginning. Many very prominent laymen in the State have expressed their conviction that our objectives are worthy of support and they are demonstrating their support by subscribing to our organization. But to be successful we must have 100 per cent support of the medical profession.

Membership in the Association entitles one to receive the monthly publication, *Modern Concepts of Heart Disease,* valuable reports and data gathered by all committees, and to receive the benefits of all our proceedings. Dues are very nominal, being only $2 a year. Correspondence is invited.

45 Second Street. Very sincerely yours,
JOHN C. RUDDOCK,

Concerning rabies in City and County of San Francisco.

(COPY)

San Francisco,
December 20, 1937.

Subject: Possibility of Rabies in San Francisco in Animals and in Humans.

To the Editor:—It will be of interest to note that the last case of human rabies reported in San Francisco occurred in 1913, following an intensive outbreak in dogs in 1912. This particular occurrence is of interest to the writer personally, since the outbreak of rabies in California in 1912 brought him originally to California in the same year to establish a Pasteur Institute at the University of California.

There were reported in San Francisco in 1912, two hundred and eighty-two animals suffering from rabies, mainly dogs. The last reported rabies in dogs in San Francisco occurred in 1929. Within the last two weeks two animals (dogs) suffering from rabies have been reported from Daly City, practically on the border line of the City and County of San Francisco.

It will be of further interest to note that since 1920 there have been reported in the State of California 13,128 animals with rabies and fifty-two deaths in human beings from the same disease. The greatest number ever reported in any single year has occurred in the past year, 1937, namely, 2,062 cases of rabies in animals with two cases in human beings. Of course, it is definitely understood that rabies in human beings or animals is 100 per cent fatal, there being no known cure or treatment when the disease becomes manifest.

It is because of the close proximity of recent cases in Daly City that the above facts have been ascertained and that definite warning is given accordingly. This warning is of particular significance to the Society for the Prevention of Cruelty to Animals inasmuch as they have control of stray animals, especially dogs and cats which are the reservoir of the disease. The area in the City and County of San Francisco nearest Daly City is our present danger spot, and we are requesting the Society for the Prevention of Cruelty to Animals to concentrate on the capture of stray dogs in this vicinity. If any dog is known to have been bitten by another animal suffering from rabies it is best to destroy it, inasmuch as the incubation period may extend from two weeks to six months and perhaps longer. Moreover, the present immunication of dogs that have been exposed to the disease has not always proved a practical procedure. The immediate treatment of dog bite is the immediate use of fuming nitric acid cauterization of the bitten area, and the report of the occurrence to the Department of Public Health.

Office of Director of Public Health,
City and County of San Francisco.

Sincerely,
J. C. GEIGER, M.D.,
Director.

Concerning California Postgraduate Supplement.

South Bend, Indiana,
December 6, 1937.

Dear Doctor Warnshuis:

Thank you very much for the supplement to CALIFORNIA AND WESTERN MEDICINE, giving the five-year study program for graduates in medicine.

I am tremendously interested in the subject of "Postgraduate Education." I believe that the maintenance of high standards of medical service is of the very greatest importance to the future of medicine as against various schemes for socialization.

Please convey my congratulations to Chairman Ruddock and his Committee for a very good piece of work.

Sincerely yours,
(Signed) R. L. SENSENICH. M.D.*

Concerning botulism outbreak in Tucumcari, New Mexico.

OFFICE OF
DIRECTOR OF PUBLIC HEALTH
CITY AND COUNTY OF
SAN FRANCISCO

November 19, 1937.

To the Editor:—Relative to the news report of an outbreak of botulism in New Mexico, I am sending you copy of a telegram sent this day to the Health Officer, Tenth District, Portales, New Mexico.

Sincerely,
J. C. GEIGER, M.D.,
Director.

* * *

(COPY)
WESTERN UNION

November 19, 1937.

Dr. L. A. Dewey
Health Officer, Tenth District
Portales, New Mexico

Re botulism outbreak Tucumcari [an] apparent favorable result. Similar outbreak [in] San Francisco [was] experienced after intravenous injection [of] one thousand cc. 10 per cent glucose solution, administered daily, according to indications. Dosage given for adults. Children according to weight.

J. C. GEIGER, M.D.,
Director, Public Health.

Concerning leaflets by the Nursing Information Bureau.

New York, November 1, 1937.

Dear Editor:

Physicians more frequently, probably, than any other group of individuals, are consulted by young people who want to be nurses. Parents, too, who are concerned for their children's welfare, turn to their doctors for answers to such important questions as, "Is there a future in nursing for my child?" "Will she make a good nurse?" "What is the best nursing school for her to attend?"

The Nursing Information Bureau of the American Nurses' Association now has available two vocational pam-

* Doctor Sensenich is a member of the Board of Trustees of the American Medical Association.

phlets which should prove useful tools to physicians and others who are asked for this type of advice. They are designed for high school and college students interested in nursing, and discuss the opportunities within the profession, the meaning of "training," how to choose a nursing school, and the general admission requirements of nursing schools. Copies may be had on application to the American Nurses' Association, 50 West Fiftieth Street, New York City.

Sincerely yours,

MARY M. ROBERTS,
Director, Nursing Information Bureau.

Concerning appreciation for a talk on "Social Medicine."

(COPY)

WESTWOOD VILLAGE KIWANIS CLUB
Westwood Village, Los Angeles,
December 18, 1937.

Mr. S. K. Cochems,
Executive Secretary, Los Angeles
County Medical Association,
Los Angeles, California.
Dear Mr. Cochems:

In behalf of the Westwood Village Kiwanis Club, I want to take this opportunity to express to you their appreciation of the splendid talk which you gave before our Club under date of December 17, 1937. The subject which you chose, namely, "Social Medicine," was a very timely one and one which should be well followed out in order to protect the profession which you represent.

Personally, I only feel sorry that more of our big business enterprises are not equipping themselves with speakers to combat this present-day element which has been devastating our business and professional people for the past several years. However, as stated by you, that advising the communities and organizing to get people interested in this so-called social insurance should be handled through many businesses and organizations to get results. I know for one organization, namely, the Westwood Village Kiwanis Club, you will find them wholly in accord with your message.

I personally want to thank you for giving your valuable time in appearing before our Club, and I want to extend to you a personal invitation to visit our Club and partake of our fellowship at any time you happen to be in Westwood Village. With best wishes for a Merry Christmas and a Prosperous New Year,

Very truly yours,

CARL G. CHOLCHER,
President.

Concerning the Advisory Board for Medical Specialties.

New York, N. Y., November 4, 1937.

To the Editor:—The Advisory Board for Medical Specialties adopted the following resolution at its meeting in Atlantic City on June 6, 1937:

Resolved, That the President appoint four members of the Advisory Board for Medical Specialties with power to add to their number and to form a Commission on Graduate Medical Education to study the problems of graduate and postgraduate medical training, such a Commission to be comprised of representatives of the medical profession, the hospitals, the universities, the medical schools, and the licensing bodies.

In keeping with that action, may I report that a Commission on Graduate Medical Education has been created, the personnel of which is attached.

The Commission will undertake to mobilize current opinions as to how the problems in this field can best be solved and to formulate the educational principles involved in graduate and postgraduate medical training. It is hoped that standards of training can be drawn up which will be of help to the Council on Medical Education and Hospitals and other agencies concerned with the inspection and evaluation of the facilities needed. There would be no duplication of effort nor conflict with the Council and these other agencies. The results of the studies by the Commission should be of real assistance to the specialty boards, the medical profession, hospitals, medical schools, state boards of medical examiners, and other institutions and organizations concerned with this phase of American medicine.

630 W. 168th Street.

Sincerely yours,

WILLARD C. RAPPLEYE, M.D., *President.*

* * *

ADVISORY BOARD FOR MEDICAL SPECIALTIES

Organized in 1933-1934 for the purpose of coördinating graduate education and certification of medical specialists in the United States and Canada.

This Board reports to and functions in conjunction with the Council on Medical Education and Hospitals of the American Medical Association.

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Willard C. Rappleye, M.D., President, New York, N. Y.
W. P. Wherry, M.D., Vice-President, Omaha, Nebraska
Paul Titus, M.D., Secretary-Treasurer, Pittsburgh, Pennsylvania.
R. C. Buerki, M.D., Madison, Wisconsin.
W. B. Lancaster, M.D., Boston, Massachusetts.

MEMBER ORGANIZATIONS AND REPRESENTATIVES

(Names marked with an asterisk (*) are the corresponding secretaries of the respective boards.)

The Association of American Medical Colleges
*Louis B. Wilson, M.D., Mayo Foundation, Rochester, Minnesota.
Willard C. Rappleye, M.D., 630 W. 168th Street, New York, N. Y.

The American Hospital Association
*R. C. Buerki, M.D., 1300 University Avenue, Madison, Wisconsin.
G. Harvey Agnew, M.D., Canadian Medical Association, 184 College Street, Toronto, Canada.

The Federation of State Medical Boards of the U. S. A.
G. M. Williamson, M.D., 2½ South Third Street, Grand Forks, North Dakota.
*Harold Rypins, M.D., State Education Building, Albany, New York.

The National Board of Medical Examiners
*J. Stewart Rodman, M.D., 225 South Fifteenth Street, Philadelphia, Pennsylvania.
Waller S. Leathers, M.D., Vanderbilt University School of Medicine, Nashville, Tennessee.

The American Board of Ophthalmology
Walter B. Lancaster, M.D., 520 Commonwealth Avenue, Boston, Massachusetts.
*John Green, M.D., 3720 Washington Boulevard, St. Louis, Missouri.

The American Board of Otolaryngology
H. P. Mosher, M.D., 828 Beacon Street, Boston, Massachusetts.
*W. P. Wherry, M.D., 1500 Medical Arts Building, Omaha, Nebraska.

The American Board of Obstetrics and Gynecology
Joseph L. Baer, M.D., 104 South Michigan Avenue, Chicago, Illinois.
*Paul Titus, M.D., 1015 Highland Building, Pittsburgh, Pennsylvania.

The American Board of Dermatology and Syphilology
Howard Fox, M.D., 140 East Fifty-fourth Street, New York, N. Y.
*C. Guy Lane, M.D., 416 Marlborough Street, Boston, Massachusetts.

The American Board of Pediatrics
Borden S. Veeder, M.D., 3720 Washington Boulevard, St. Louis, Missouri.
*C. Anderson Aldrich, M.D., 723 Elm Street, Winnetka, Illinois.

The American Board of Psychiatry and Neurology
Franklin G. Ebaugh, M.D., Colorado Psychopathic Hospital, Denver, Colorado.
*Walter Freeman, M.D., 1028 Connecticut Avenue, Washington, D. C.

The American Board of Radiology
A. C. Christie, M.D., 1835 Eye Street, N. W., Washington, D. C.
*B. R. Kirklin, M.D., Mayo Clinic, Rochester, Minnesota.

The American Board of Orthopedic Surgery
Willis C. Campbell, M.D., 869 Madison Avenue, Memphis, Tennessee.
*Fremont A. Chandler, M.D., 6 North Michigan Avenue, Chicago, Illinois.

The American Board of Urology
Herman L. Kretschmer, M.D., 122 South Michigan Boulevard, Chicago, Illinois.
*Gilbert J. Thomas, M.D., 1009 Nicollet Avenue, Minneapolis, Minnesota.

The American Board of Internal Medicine
*Walter L. Bierring, M.D., Suite 1210, 406 Sixth Avenue, Des Moines, Iowa.

O. H. Perry Pepper, M.D., Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania.
The American Board of Pathology
A. H. Sanford, M.D., Mayo Clinic, Rochester, Minnesota.
*F. W. Hartman, M.D., Henry Ford Hospital, Detroit, Michigan.
The American Board of Surgery
Erwin R. Schmidt, M.D., Wisconsin General Hospital, Madison, Wisconsin.
*J. Stewart Rodman, M.D., 225 South Fifteenth Street, Philadelphia, Pennsylvania.

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MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

Responsibility of Physician for Acts of Nurse: Doctrine of Res Ipsa Loquitur in Cases of Treatment by Means of Infra-Red Rays

The District Court of Appeal for the Third Appellate District has just decided the case of *McCullough* vs. *Langer*, 91 Cal. App. Dec. 444, in which the facts were these: Plaintiff commenced action against a physician and a nurse employed by the physician for alleged improper use of an infra-red incandescent lamp which caused permanent injury to plaintiff's leg in the nature of a third-degree burn. A jury returned a verdict in favor of the nurse, but against the physician. Two physicians testified for the plaintiff that the third-degree burn was the result of submitting tender devitalized flesh of a bruised thigh to extreme heat from the infra-red light for too great a length of time. It further appeared from plaintiff's testimony that a compress was placed over plaintiff's bruised thigh and left undisturbed over the wound with the heat of the lamp applied thereto for more than four hours without any effort being made by the physician to ascertain the result of such treatment. Plaintiff introduced evidence to the effect that the lamp would generate 140 degrees of heat in one hour and that the maximum heat which should be applied to that wound, under the circumstances, was not to exceed 110 degrees Fahrenheit.

The defendant physician appealed from the judgment against him, and two of the reasons which he urged for reversal of the judgment were:

1. That the exoneration of the nurse from negligence exempted him from liability because the nurse actually administered the infra-red heat treatment, and

2. That the trial court erroneously applied the doctrine of *res ipsa loquitur*.

With respect to the first contention of the defendant physician the District Court of Appeal held that since the nurse was acting under the direction of the physician and not acting independently, the physician was liable not merely because he was the nurse's employer, but also because he was a joint participant in the act complained of by the plaintiff. The following portion of the Court's opinion indicates the tremendous legal responsibility placed upon physicians for the acts of nurses and other assistants:

> Under the circumstances of this case the nurse was presumed to attend the patient under the supervision and direction of her employer, Doctor Langer. As the *McInerney* case, *supra*, states, the employer "was therefore liable not merely under the rule of respondeat superior, *but rather as a joint participant in the acts complained of.*" (*Armstrong* vs. *Wallace*, 8 Cal. App. (2nd) 429, 439.) In the case last cited, this Court said:
>
> "The surgeon had the power and, therefore, the duty to direct the nurse to count the sponges as a part of his work in the opening and closing of plaintiff's abdomen and the putting in and taking out of sponges, and *it was his responsibility to see that such work was done.*"

In the present case it was the *duty* of the doctor in his treatment of the patient to see that the compress and lamp were used in such a manner as to prevent the application of excessive heat and a consequent burning of the flesh. The supervision of the doctor is shown by his personal visits to the room of the patient and by the inquiry of the nurse addressed to him an hour before the burn was discovered as to whether she should not then change the compress and lamp, to which he replied, "Leave them until after his evening meal." The appellant was, therefore, not relieved of liability because of the verdict favorable to his codefendant.

With respect to the defendant physician's second contention, namely, that the trial court erroneously instructed the jury that the doctrine of *res ipsa loquitur* applied to the case, the District Court of Appeal stated that *res ipsa loquitur* ("the thing speaks for itself") applies to cases involving the negligence of a physician in the use of x-ray pictures taken for the purpose of diagnosing an ailment and also in the manner of actually treating the disorder. The Court said that in the present case the plaintiff was burned in some way unknown to him and as a result of the treatment of his injury by the physician and the nurse in his employ. It occurred while he was under the influence of opiates, which prevented him from knowing just what caused the burn. The Court then held that, under such circumstances, the doctrine of *res ipsa loquitur* was applicable and that the burden was on the physician to show that the third-degree burns were not occasioned by his negligence.

Hence, the court held mere proof that he was burned while undergoing treatment through the use of an infra-red incandescent lamp was sufficient to sustain the plaintiff's case and to cast responsibility upon the physician. The physician then had the burden of convincing the jury that he was not at fault.

† Editor's Note.—This department of California and Western Medicine, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

DR. PHILIP MILLS JONES (1870–1916)*

Philip Mills Jones, M.D., a member of the Board of Trustees of the Association, secretary of the Medical Society of the State of California, and editor of the "California State Journal of Medicine" died in San Francisco, November 27, 1916, from pneumonia.

He was born in Brooklyn, January 17, 1870, and after attending the Polytechnic Institute of Brooklyn, from which he was graduated in 1886, he entered the academic course in New York University and then took his course in medicine at the Long Island College Hospital, Brooklyn, and was graduated in 1891. After practicing in Brooklyn until 1900, he moved to California and became associated with the University of California, in the Department of Archeology. He took a prominent part in the reorganization of the Medical Society of the State of California in 1902 and since that time had been secretary of that constituent state association and editor of its official organ. In order to serve his state association more effectively, and because he had found difficulty in securing lawyers who appreciated the medical phases of legal questions, in October, 1916, Doctor Jones passed the necessary examinations and was admitted to the bar to practice as an attorney and counselor at law in all the courts in the State of California.

He represented his state association in the House of Delegates of the American Medical Association continuously from the session of 1903 to the session of 1908. At this latter session he was elected a member of the Board of Trustees of the American Medical Association and served in that capacity up to the time of his death. He was a member of the National Committee of One Hundred on

* Editor's Note.—In connection with comment made in this issue, concerning the late Philip M. Jones, founder-editor of the official journal of the California Medical Association, and because it has taken months to locate a photograph of Doctor Jones, the obituary notice which appeared in the *Journal of the American Medical Association* of December 2, 1916, is here reprinted for the information of present-day members, and as a contribution to the historical files of the California Medical Association. For editorial comment, see page 1.



PHILIP MILLS JONES, M. D.
1870-1916

Public Health and a Fellow of the American Academy of Medicine.

Besides possessing the ability to write in a brilliant and convincing style, Doctor Jones was an effective and forceful public speaker and devoted much time and energy to the propaganda for public-health measures throughout California and the other Pacific states.

For eight years Dr. Philip Mills Jones was a member of the Board of Trustees, in which position he worked faithfully, and was fearless in his stand for what he believed to be right and just. He was secretary of the Medical Society of the State of California and editor of its journal for fifteen years, and it was in these offices that his most effective work was done. Through his efforts the California profession developed one of the best organizations of any state—one that is doing splendid work—professionally, socially, and scientifically. He made the "California State Journal of Medicine" a publication of influence not only within its own territory, but also in other parts of the country. As editor of this journal, Doctor Jones was especially fearless in his attacks on fraud and quackery, whether it concerned the proprietary medicine evils or quackery as it related to the medical profession.

BASIC SCIENCE ACT*

Draft of Proposed Law

An Act to establish a state board of examiners in the basic sciences underlying the practice of the healing art, to provide for its organization and powers, to provide that certification by that board be a prerequisite to eligibility for examination for license to practice the healing art, and to define the healing art.

Note.—In some states the constitutions require that the title of an act express the purposes and contents of the act. The title set forth above will, it is believed, conform to such a requirement.

Be it enacted.

Note.—The enacting clause should follow the form customary in the state.

Section 1. *Basic Science Certificate Required.*—No person shall be permitted to take an examination for a license to practice the healing art or any branch thereof, or be granted any such license, unless he has presented to the board or officer empowered to issue such a license as the applicant seeks, a certificate of ability in anatomy, physiology, chemistry, bacteriology, and pathology (hereinafter referred to as the basic sciences), issued by the state board of examiners in the basic sciences.

Note.—The sciences named are those that may be fairly said to have the same implication, whether the practitioner proposes to practice nonsectarian medicine or to follow the dogma of some cult. Whatever may be said of separate licensing boards for the nonsectarian practitioner and the cultists, there seems to be no valid argument against a uniform examination in the basic sciences, particularly if the examination is conducted, as is here proposed, by persons who are not active practitioners of the healing art.

Section 2. *Healing Art Defined.*—For the purposes of this Act, the healing are includes any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition.

Note.—This definition brings within its scope nonsectarian medicine, osteopathy, chiropractic, naturopathic, sanipractic, and other modes of healing. It is inclusive enough to cover dentists, nurses, chiropodists, pharmacists, optometrists, and others, but Section 17 excepts them from the operation of the Act.

Section 3. *Board of Examiners in the Basic Sciences Authorized.*—The Governor, within thirty days after this Act takes effect, shall appoint a state board of examiners in the basic sciences (hereinafter referred to as the board), consisting of five members. The members of said board shall be appointed one for one year, one for two years, one for three years, one for four years, and one for five years, from the dates of their respective appointments. On the expiration of the term of any member, the Governor shall fill the vacancy by appointment for a term of five years. On the death, resignation, or removal of any member, the Governor shall fill the vacancy by appointment for the unexpired portion of the term. Every member shall serve until his successor is appointed and qualified. The members of the board shall be selected because of their knowledge of the basic sciences aforesaid, and each member shall be a professor, or an assistant or associate professor, or an instructor on the faculty of the ———— or some other institution of learning in the State of ———— of equal rank. Each member shall have resided in ———— not less than one year next preceding his appointment. No member of the board shall be actively engaged in the practice of the healing art or of any branch thereof.

Note.—This section aims at the creation of an examining board in which, by reason of the overlapping of the terms of members, there will be a continuity of policy and administration. The section proposes to limit the appointment of members of the basic science board to members of the faculties of approved universities and colleges, if possible. There should be inserted at the appropriate place the name or names of such school or schools.

Section 4. *Organization of Board.*—The board shall organize as soon as practicable after its appointment. It shall have authority to elect officers, to adopt a seal, and to make such rules as it deems expedient to carry this Act into effect. The board shall keep a record of its proceedings, which shall be *prima facie* evidence of all matters contained therein. Every member shall receive ———— dollars per diem and actual expenses, when actively engaged in the discharge of his duties. The compensation of the members and the other expenses of the board shall be paid out of the fees received from applicants, but this is not to be construed as preventing appropriations to cover deficits. The treasurer of the board shall give such bond, running in favor of the State, as the State Treasurer may determine. The office of the board shall be in the state capital, and quarters for that office shall be assigned in the capitol building or some other building occupied by the state government.

Section 5. *Fees Payable by Applicants.*—The fee for examination by the board shall be ———— dollars. The fee for reëxamination within any twelve-month period shall be ———— dollars, but the fee for reëxamination after the expiration of twelve months shall be the same as the original fee. The fee for the issue of a certificate by authority of reciprocity, on the basis of qualifications as determined by the proper agency of some other state, territory, or the District of Columbia, shall be ———— dollars. All fees shall be paid to the board by the applicant when he files his application. The board shall pay all money received as fees into the state treasury, to be placed in a special fund to the credit of the board. The State Treasurer shall pay out of such fund all expenses incurred by the board, on vouchers signed by the president and the secretary of the board.

Section 6. *Examinations.*—The board shall conduct examinations at such times and places as it deems best. Every applicant, except as hereinafter provided, shall be examined

* Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, Chicago. Reprinted in California and Western Medicine for its suggestive value to members of the California Medical Association.

to determine his knowledge, ability, and skill in the basic sciences. The examinations shall be conducted in writing, but may be supplemented by oral examinations, and if practicable shall be supplemented by examinations in the laboratory, dissecting room, and dispensary, and at the bedside. If the applicant receives a credit of 75 per cent or more in each of the basic sciences, he shall be considered as having passed the examination. If the applicant receives less than 75 per cent in one subject and receives 75 per cent or more in each of the remaining subjects, he shall be allowed a reëxamination at the examination next ensuing, on application and the payment of the prescribed fee, and he shall be required to be reëxamined only in the subject in which he received a rating less than 75 per cent. If the applicant receives less than 75 per cent in more than one subject, he shall not be reëxamined unless he presents proof, satisfactory to the board, of additional study in the basic sciences sufficient to justify reëxamination.

Section 7. *Requirements for Certificate.*—No certificate shall be issued by the board unless the person applying for it submits evidence, satisfactory to the board, (1) that he is not less than twenty-one years old; (2) that he is a person of good moral character; (3) that before he began the study of the healing art he was graduated by a high school accredited by the [insert state accrediting agency] or a school of similar grade, or that he possesses educational qualifications equivalent to those required for graduation by such an accredited high school; and (4) that he has a comprehensive knowledge of the basic sciences as shown by his passing the examination given by the board, as by this Act required. This shall not be construed to prevent the issue of certificates under the provisions of Section 8 of this Act.

Note.—No evidence is required of the applicant of the extent and nature of his knowledge of the basic sciences. These are to be determined by the board of examiners in the basic sciences by examination. The professional examining board to which the applicant must subsequently apply for his examination for license to practice is to be at liberty, it is proposed by Section 18, to accept the findings of the state board of examiners in the basic sciences with respect to the proficiency of the applicant in those sciences, or to reëxamine the applicant in those sciences on its own account.

Section 8. *Reciprocity.*—The board may in its discretion waive the examination required by Section 7, when proof satisfactory to the board is submitted, showing (1) that the applicant has passed in another State an examination in the basic sciences either before a board of examiners in the basic sciences or before a state board authorized to issue licenses to practice the healing art; (2) that the requirements of that state are not less than those required by this Act as a condition precedent to the issue of a certificate; and (3) that the board of examiners in the basic sciences in that state grants like exemption from examination in the basic sciences to persons holding certificates from the state board of examiners in the basic sciences of ———— or holding licenses to practice the healing art according to the method or school that the applicant proposes to follow, issued after examination by the proper licensing board of ————.

Section 9. *Appeals.*—Any person aggrieved by any action of the board may appeal to the ———— court of the county in which the appellant has his residence. Such appeal shall be taken by serving on the secretary of the board a notice of appeal, stating the action from which the appeal is taken and, if the appeal is from an order of the board, stating such order or the part thereof from which the appeal is taken, and filing with the secretary of the board a bond in the sum of $500, conditioned for the payment of all costs of the appeal and all damages sustained by any person because of the appellant's failure to comply with the terms of the action or order of the board, if such action or order be held to be legal and valid. On the filing and approval of such bond, the action or order, or the part thereof appealed from, shall be stayed pending the final determination of the controversy. Immediately on the perfecting of such appeal the secretary of the board shall transmit to the clerk of the court of such county the notice of the appeal and the bond, and a certified copy of all proceedings of the board relating to the action or order from which the appeal is taken; and such cause shall thereupon stand for trial at the first regular term of the court thereafter.

Section 10. *Certificates and Licenses Void.*—Any basic science certificate and any license to practice the healing art or any branch thereof, issued contrary to this Act, is void. Any licensing board which has issued a license on the basis of a void basic science certificate shall revoke or cancel that license. The procedure for such revocation or cancellation shall be in accordance with the provisions of the Act under which such license was issued, authorizing the cancellation or revocation of licenses generally. The certificate issued to any person by the state board of examiners in the basic sciences shall be revoked automatically by the revocation of his license to practice the healing art or any branch thereof.

Section 11. *Practice Without Basic Science Certificate Forbidden.*—Any person who practices the healing art or any branch thereof without having obtained a valid certificate from the state board of examiners in the basic sciences, except as otherwise authorized by this Act, shall be fined not more than ———— dollars or imprisoned for not more than ————, or both, in the discretion of the court.

Note.—The exception referred to in this section is governed by Section 17 of this Act.

Section 12. *Fraudulent Certificates Forbidden.*—Any person who obtains or attempts to obtain a basic science certificate by dishonest or fraudulent means, or who forges, counterfeits, or fraudulently alters any such certificate, shall be fined not more than ———— dollars or imprisoned not more than ————, or both, in the discretion of the court.

Section 13. *Fraudulent Licenses Forbidden.*—Any person who obtains or attempts to obtain a license to practice the healing art or any branch thereof from any board or officer authorized to issue any such license, without presenting to said board or officer a valid certificate issued to the applicant by the state board of examiners in the basic sciences, as in this Act required, shall be fined not more than ———— dollars or imprisoned not more than ————, or both, in the discretion of the court.

Section 14. *Issue of Fraudulent Licenses Forbidden.*—Any person who knowingly issues or participates in the issue of a license to practice the healing art or any branch thereof (1) to any person who has not presented to the licensing board a valid certificate from the state board of examiners in the basic sciences or (2) to any person who has presented to such licensing board a certificate obtained from the state board of examiners in the basic sciences by dishonesty or fraud, or any forged or counterfeit certificate, shall be fined not more than ———— dollars or imprisoned not more than ————, or both, in the discretion of the court.

Section 15. *Fees Paid Unauthorized Practitioners Recoverable.*—A person who has paid money or anything of value to a person not authorized to practice the healing art or any branch thereof, as compensation for services rendered in the practice of the healing art or any branch thereof, when the payor did not know at the time of payment that the payee was neither the holder of a certificate issued by the state board of examiners in the basic sciences nor authorized to practice without such a certificate, may recover such money or the value of the thing paid, by an action at law instituted within two years from the date of payment.

Section 16. *Enforcement.* — The state board of examiners in the basic sciences and the several boards authorized to issue licenses to practice the healing art and branches thereof shall investigate every supposed violation of this Act coming within the scope of the authority of such boards respectively, and report to the proper ———— attorney all cases that in the judgment of the board warrant prosecution. Every police officer, sheriff, and peace officer shall investigate every supposed violation of this Act that comes to his notice or of which he has received complaint and apprehend and arrest all violators. It shall be the duty of the attorney-general and of the several ———— attorneys to prosecute violations of this Act.

Section 17. *Exceptions.*—This Act shall not be construed as applying to dentists, pharmacists, nurses, optometrists, and chiropodists, practicing within the limits of their respective callings; nor to persons licensed to practice the healing art or any branch thereof in ———— when this Act takes effect; nor to persons specifically permitted by law to practice without licenses, who practice each within the limits of the privilege thus granted to him.

SECTION 18. *Saving Clause.*—Nothing in this Act shall be construed as repealing any statutory provision in force at the time of its passage with reference to the requirements governing the issue of licenses to practice the healing art or any branch thereof or as in any way lessening such requirements. But any board authorized to issue licenses to practice the healing art or any branch thereof may in its discretion either accept certificates issued by the ———— board of examiners in the basic sciences in lieu of examining the certificants in such sciences or it may examine such certificants in such sciences. The unconstitutionality of any part of this Act shall not be construed as invalidating any other separable part of it.

SECTION 19. *Short Title.*—This Act may be cited as Basic Science Act, 19——.

SECTION 20. *Repeal.*—All Acts and parts of Acts contrary to the provisions of this Act or inconsistent therewith are hereby repealed.

DOUGLASS W. MONTGOMERY*

Doctor Kelly has very graciously accorded me the privilege of saying a few words concerning our friend and colleague who is with us here tonight.

Too often we turn to the pages of our *Bulletin* and read an epitaph of a colleague no longer with us. Happily, tonight, while he *is* with us, we pause a few moments in our busy lives to pay tribute to Douglass Montgomery.

He has not only reached that enviable milestone in medicine, of a half-century of practice, but has accomplished still more; he now approaches his fifty-second year of continuous practice in San Francisco, and has been a generous member of the San Francisco County Medical Society most of those years. The archives of the American Medical Association reveal that only one physician in many thousands ever remains in active practice fifty years.

To get Doctor Montgomery to talk about himself is most difficult, as even there one encounters that Scotch trait of a bit of hesitancy in giving something away, including facts about himself. But having observed him occasionally for twenty years, I've garnered a few facts of interest to us. Canadian born, in 1859, of Scotch and Welsh parents, he was graduated from Upper Canada College, then attended Toronto Medical School for three years, going to Columbia for his final year, where he was graduated in 1882. After some time as chief of staff with the famous Halstead and Bull in New York, he went to Europe. There followed a productive three years in Italy, Heidelberg, Wurzberg, Vienna, Switzerland, London, and finally Edinburgh.

Then strangely enough a war brought him to San Francisco—a war between two railroads. One May day in 1886, he was strolling along the streets of St. Paul, Minnesota. The only two railroads to the West were having a rate war—even then. Douglass saw a sign which read: "$17.00 to Sacramento, California." He blinked his eyes and looked again; naturally, to a Scotchman that was like waving a red flag at a bull. His hand being in his pocket at the time, all he had to do was draw out the money and he was aboard. Luckily, it was spring, and as the train rolled over the blooming desert, Douglass congratulated himself upon getting to God's country for $17 and he stayed. Thus since May, 1886, San Francisco has had his valued services, first as the initial professor of pathology in the Toland Medical College for about five years; since then as one of the deans of dermatology of the West.

Doctor Montgomery is certainly the antithesis of Osler's famous remark about "the uselessness of men above sixty years of age . . . in professional life. . . ." He is proof that nobody grows old by merely living a number of years. People only grow old by deserting their ideals, and his are still with him.

As he approaches his seventy-ninth year of life, he walks daily from Fillmore and Vallejo streets to his office down town. He is in his office at ten in the morning and leaves late in the afternoon. His step is brisk, his carriage erect, and his energy remarkable.

For many years I've watched him in what would be our spare moments. On the automobile ferry, on a country hillside, in his office between patients, and in his home, I've seen him slyly withdraw a small volume in Greek, where an hour of counsel with one of the old masters would be had. And when one turns to literature for observations upon old age, one finds that it is the trend of the times to eulogize youth, and one quickly turns back to these very philosophers the doctor has never deserted. May I remind him of Cicero's words: "The fruit of old age is the memory of abundant blessings previously acquired." And again he wrote: "It is in the old men that reason and judgment are found, and had it not been for old men, no state would have existed at all."

Our own Oliver Wendell Holmes remarked that "to be seventy years young is sometimes far more cheerful and hopeful than to be forty years old."

I'm going to plagiarize from another author because I feel it is applicable to our guest tonight. In 1902, Sir William Osler wrote a tribute to the famous Alfred Stille; from that address I pluck the following: "Take the list of fellows of our Society, look over the names and dates of graduation of the practitioners of this city, and the men above seventy years of age form, indeed, a small remnant. All the more reason that we should cherish and reverence them. I only knew . . . after his seventieth birthday . . . the keenness of his mind on all questions relating to medicine. He had none of those unpleasant senile vagaries, the chief characteristic of which is an intense passion for opposition for everything that is new. He had that delightful equanimity and serenity of mind which is one of the most blessed accomplishments of old age. He had none of the irritating features of the old doctor who, having crawled out of the stream about his fortieth year, sits on the bank, croaking of misfortunes to come, and with less truth than tongue, lamenting the days that have gone and the men of the past."

I know of no one who has more thoroughly enjoyed the advance of the world than Douglass Montgomery. Last August 3, on his seventy-eighth birthday, he was merrily ensconced in a single motor plane with a Chinese pilot, flying up the Yangtze River of China, with his loyal wife and constant companion. The two of them made the round trip to China on the *Clipper* and, besides, went inland on rather doubtful planes.

His willingness to change to the new is best evidenced by what he told me last week. After being a Republican for seventy-eight years, and as well believing in a balanced diet and plenty of sleep, he discovered that Vice-President Garner goes to bed right after supper. Just a slight push and he'll be a Democrat. And as a modern story teller, he's a match for Tom Kelly, Junius Harris, or Morris Fishbein, any day in the week.

Doctor Montgomery, we're going to ask you to give us the secret of this fruitful life. Is it merely balanced diet and plenty of sleep; is it the hours of philosophizing you've had with ancient Greece and Rome; or is it the fact, being a dermatologist, you have taken advantage of the scientific fact that the skin of woman emits wavelengths of 9,440 millimicrons and thereby received some transmutation of energy? In other words, we want to know how one can remain in a skin game for fifty-six years and get away with it so well.

Whatever the reason be, we pause tonight to pay you tribute for your accomplishment. With that in mind, we have prepared a resolution which Doctor Kelly will submit to a vote here this evening. The following resolution will be duly engraved and presented to you as a constant reminder in the years to come, of the words of the Roman poet, Ovid, that "Time is generally the best medicine."

HAROLD M. F. BEHNEMAN.

* * *

RESOLUTION

WHEREAS, Our friend and colleague, Douglass W. Montgomery, has not only continuously and successfully practiced medicine in this city for over fifty years, but is still energetically pursuing that art according to the ethics and oath of Hippocrates; be it

Resolved, That *his* friends, the members of the San Francisco County Medical Society, herein acknowledge that unusual accomplishment, and offer to him their heartfelt felicitations and sincere good wishes for continued health and happiness.

* A Tribute: Given at a meeting of the San Francisco County Medical Association on December 14, 1937.

PACIFIC COAST ABORTION RING: CALIFORNIA SUPREME COURT DECISION*

Opinion follows:

89 Cal. App. Dec. 393—No. 3322.

Los Angeles—Arthur Crum, Judge.

Crim. No. 4116. In Bank. November 26, 1937

The People of the State of California, Plaintiff and Respondent, vs. R. L. Rankin, George E. Watts, John A. Creeth, J. O. Shinn, William A. Byrne, Valentine St. John, H. L. Houston, Bessie McCarthy, Grace Moore, Lillian Wilson, Jessie Radcliffe, James Beggs, Beatrice Bole, Jesse C. Ross, Violette Pellegrini, W. Norman Powers, and J. C. Perry, Defendants; William A. Byrne, Valentine St. John, James Beggs, and Jesse C. Ross, Defendants and Appellants.

For Appellant James Beggs—Clarence W. Hull; Sherman & Sherman.

For Appellant Valentine St. John—Charles A. Thomasset.

For Appellant William A. Byrne—R. E. Parsons, Jerome O. Hughes.

For Appellant Jesse C. Ross—Abe Richman.

For R. L. Rankin and William A. Byrne—Rosecrans & Emme, Bayard R. Rountree.

For Appellants—Anna Zacsek.

For Respondent—U. S. Webb, Attorney-General; Bayard Rhone, Deputy Attorney-General; Buron Fitts, District Attorney; Verne L. Ferguson, Deputy District Attorney.

This cause was taken over after decision in the District Court of Appeal of the Second Appellate District, Division Two, in order that we might more fully examine the record and certain issues raised upon the appeal. An examination of the evidence, covering 1,742 pages of the reporter's transcript, compels us to agree with the conclusion of the Appellate Court that as to the appellants Beggs, Ross, and St. John there is a dearth of corroborating evidence within the meaning of Section 1111 of the Penal Code as interpreted in *People* vs. *Kempley*, 205 Cal. 441, 271 Pac. 478, and *People* vs. *Davis*, 210 Cal. 540, 293 Pac. 32. However, we cannot accept the conclusion announced by that court with reference to the contention of the appellant Byrne directed against Count 7 of the indictment. This point will be discussed later.

Therefore, with such additional comment as shall hereinafter appear, we adopt the following portions of the opinion of Mr. Justice McComb as and for the decision of this court:

"Defendants were accused by the grand jury of the county of Los Angeles of the crime of conspiracy to violate Section 274 of the Penal Code, a felony, and in eight separate counts of having committed abortions. Defendants were tried jointly before a jury, whose verdicts were:

"1. Guilty:

"(Counts, 1. 2, 5, 7, and 9): R. L. Rankin, George E. Watts, J. O. Shinn, William A. Byrne, Grace Moore, Lillian Wilson, James Beggs, Jesse C. Ross.

"(Counts 1 and 5): John A. Creeth, Valentine St. John.

"(Counts, 1, 2, and 5): Violette Pellegrini.

"2. Not guilty:

"(All counts): Jessie Radcliffe, J. C. Perry.

"Defendants H. L. Houston, Bessie McCarthy, and Beatrice Bole were not apprehended, and defendant W. Norman Powers entered a plea of guilty to Count 1 of the indictment and testified on behalf of the State.

"Defendants James Beggs, William A. Byrne, R. L. Rankin, Jesse C. Ross, and Valentine St. John alone appeal from the judgments and orders denying their motions for a new trial.

"The appeal of defendant R. L. Rankin has heretofore been dismissed at his request.

Viewing the evidence most favorable to the prosecution (*People* vs. *Dukes*, 90 Cal. App. 657, 659), the facts in the instant case are:

"Defendants R. L. Rankin and George E .Watts owned, operated, and directed a series of offices, extending from Seattle, Washington, to San Diego, California, for the purpose of illegally performing abortions. The remaining defendants, with the exception of those who were acquitted by the jury, were employed by them in various capacities in connection with the conduct of their illegal business. In the course of their business, and in pursuance of their conspiracy, abortions were performed upon Gladys Duckworth, Peggy Nowell, and Josephine Peacock, as alleged in Counts 2, 5, and 9 of the indictment.

"A.

"Each appellant urges reversal of the judgments on the ground that there is no substantial corroboration of the testimony of his accomplices to show his participation in or connection with any of the crimes of which he was convicted.

"The law is settled in California that a conviction cannot be sustained upon the testimony of an accomplice, unless it be corroborated by other evidence which tends to connect defendant with the commission of the offense charged in the indictment (Section 1111, Penal Code), and it is equally clear that the corroborative evidence necessary to comply with this requirement must of itself, without the aid of the accomplice's testimony, connect or tend to connect defendant with the commission of the offense charged. (*People* vs. *Kempley*, 205 Cal. 441, 455; *People* vs. *Janssen*, 74 Cal. App. 402, 406; *People* vs. *Rokes*, 88 Cal. App. Dec. 317, 318.)

"Applying the foregoing rules to the instant case, we find with reference to the appellants Beggs, Ross, and St. John, that, after eliminating entirely the testimony of their accomplices, the record is completely devoid of any evidence even slight, which connects or tends to connect any of them with any of the crimes of which they were convicted. Since the judgments as to these appellants must be reversed for the foregoing reason, it is unnecessary for us to consider the other contentions which they have advanced.

"With reference to appellant William A. Byrne, we find a different situation. An examination of the record discloses that, after eliminating the testimony of his accomplices, there was substantial evidence considered in connection with such inferences as the jury may have reasonably drawn therefrom to connect him with the commission of the offense charged, thus furnishing the necessary corroboration to the testimony of his accomplices. One example of such corroborative evidence is found in the testimony of Geraldine Gerding, secretary to the manager of the Ocean Center Building in Long Beach, who it is conceded was not an accomplice, to the effect that appellant Byrne, about July 29, 1936, paid rent for rooms used by some of his coconspirators in that city for the purpose of performing abortions. There is ample evidence of a similar nature; however, since no useful purpose would be subserved by setting the same forth *in extenso*, we refrain from further discussion of it. (*Thatch* vs. *Livingston*, 13 Cal. App. [2d] 202, 56 Pac. [2d] 549; *Koberle* vs. *Hotchkiss*, 8 Cal. App. [2d] 634, 48 Pac. [2d] 104; *Leavens* vs. *Pinkham & McKevitt*, 164 Cal. 242, 245, 128 Pac. 399.)

"B

"Appellant Byrne relies for reversal of the judgments upon these additional propositions:

"First: Count 7 of the indictment did not charge a public offense.

"Second: Section 274 of the Penal Code is unconstitutional in that it fails to inform a person charged there-

* Letter which follows gives additional information concerning the California Supreme Court decision in the case:

DEPARTMENT OF PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

San Francisco, Calif.,
December 10, 1937.

Re: *People vs. R. L. Rankin, et al.* (Pacific Coast Abortion Ring).

To the Editor:—We enclose herewith galley proof of the California Supreme Court decision in the case of *People* vs. *Rankin*, wherein you will note that new trials have been granted Drs. James Beggs, Jesse C. Ross, and Valentine St. John. You will also note that the State Supreme Court sustained the Los Angeles Superior Court conviction of William A. Byrne, former Assistant Special Agent of the Board of Medical Examiners.

We believe that the decision is of sufficient importance to warrant publication in the next issue of CALIFORNIA AND WESTERN MEDICINE.

Would appreciate return of galley proof when same has served your purpose.

With kindest personal regards, believe me

Very truly yours,
(Signed) C. B. PINKHAM, M.D.,
Secretary-Treasurer.

under with reasonable certainty as to what acts or actions are prohibited by it. . . .

"Appellant Byrne's final proposition is untenable. His entire argument is directed to the point that the words 'procure the miscarriage of such woman' do not convey a definite and certain meaning. 'Miscarriage' is thus defined in Bouvier's Law Dictionary, Volume 2, page 2221:

" 'The expulsion of the ovum or embryo from the uterus within the first six weeks after conception. Between that time, and before the expiration of the sixth month, when the child may possibly live, it is termed abortion. When the delivery takes place soon after the sixth month, it is denominated premature labor. But the criminal act of destroying the fetus at any time before birth is termed, in law, procuring miscarriage.'

"An almost identical definition will be found in Cyclopedic Law Dictionary, page 662, and substantially the same definition is given in each of the modern dictionaries of the English language. It is, therefore, evident that the phrase as used in the statute was sufficiently explicit to inform persons of common intelligence and understanding of the acts which were prohibited."

Even if we concede for present purposes that Count 7 of the indictment, as urged by the appellant Byrne, is deficient because of its failure to charge the aborting of a "pregnant" woman, we are of the opinion that no prejudice resulted therefrom, inasmuch as the evidence adduced upon the trial established the pregnancy of the woman involved. Therefore, under Section 4½ of Article 6 of the Constitution the assumed defect is insufficient to warrant a reversal of the judgment. (*People* vs. *Bonfanti*, 40 Cal. App. 614, 181 Pac. 80; *People* vs. *Buttulia*, 70 Cal. App. 444, 233 Pac. 401.) In the *Bonfanti* case, *supra*, the defendant was charged with assault with intent to commit rape, but the information failed to allege, as specified in Section 261 of the Penal Code, that the woman whom the defendant had assaulted was not his wife. The evidence, however, definitely indicated that she was not his wife. Under the circumstances, it was held that the defect in the information was not prejudicial in the light of Section 4½, *supra*. The reasoning of that case is applicable here, and the contention of the appellant Byrne with respect to Count 7 of the indictment does not call for a reversal of the judgment thereon.

The judgment and orders denying the motions for new trial relative to the appellants James Beggs, Jesse C. Ross and Valentine St. John are and each is reversed, and a new trial is ordered.

The judgments and orders relative to William A. Byrne on Counts 1, 2, 5, 7, and 9 are and each is affirmed.

WASTE, C. J.

We concur: Houser, J., Shenk, J., Curtis, J., Edmonds, J., Seawell, J.

MEDICAL CLINICS PLAN: PUBLIC HEALTH EXHIBITS

Golden Gate International Exposition: San Francisco

In the huge Hall of Science at the 1939 Golden Gate International Exposition, thirty of America's leading research laboratories will tell the story of the remarkable recent progress which has been made in the prevention and treatment of disease.

Led by such world-famous institutions as the Mayo Clinic, the Jackson Clinic, the American Medical Association, and the American Society for the Control of Cancer, these laboratories will present a dramatic picture of the latest advances in medicine and its related fields. The exhibit plans will also have the coöperation of the country's leading universities, notably the University of California, Stanford University, the California Institute of Technology, University of Southern California, Harvard University, University of Oregon, and the University of Washington.

According to Milton Silverman, Director of the Hall of Science for the $50,000,000 World's Fair of the West, these exhibits will place the major emphasis on the prevention of disease rather than its treatment. Following a 9000-mile trip to the outstanding laboratories and clinics of the United States, Silverman reports that amazing exhibits are being planned to illustrate the tremendous strides which are being made in research and disease prevention.

Reservations for space in the Hall of Science have already been made by the Mayo Clinic of Rochester, Minnesota, and plans are under way for a complete research exhibit at the Fair under the direction of Dr. Charles Mayo, Dr. Donald Balfour, who is now active head of the Mayo Clinic, and Dr. Walter Alvarez, internationally famous physiologist.

Supervised by Doctor Alvarez, a new and improved model of the transparent man will be shown, particularly emphasizing the digestive apparatus of the human being. From the extensive scientific museum at Rochester will come many astonishing displays built for use at the Exposition. Other material especially prepared for the Fair, will show the remarkable technique which has been attained in plastic surgery. Displays showing the prevention and treatment of appendicitis have also been promised, and educational exhibits pertaining to diabetes, asthma and experimental dentisry are also contemplated. The Mayo Clinic will also participate in the cancer exhibit and the embryological exhibit.

The Jackson Clinic of Madison, Wisconsin, will center all its efforts on one central exhibit, the story of the thyroid gland. This display will show the normal activity of the gland and how it secretes the amazing and highly powerful hormone, thyroxin. Special consideration will be given to the remarkable achievement in preventing both physical and mental destruction through the impairment of this gland and the importance of iodin in keeping the gland functioning. Attention will also be focused on the so-called goiter belt stretching across northern United States, and dynamic exhibits will demonstrate the prevention of goiter and cretinism. Dr. Arnold Jackson, head of the clinic, will personally direct these activities at the San Francisco Exposition.

Two Wisconsin schools planning to participate in the medical exhibit are the Marquette University and the University of Wisconsin. Dr. Eben J. Carey of Marquette, who was in charge of medical exhibits at the Century of Progress, is heading a group which is planning an outstanding exhibit on embryology, "How Life Begins."

At the University of Wisconsin an exhibit is being prepared to show the modern use of drugs and chemical to alleviate pain. In a coöperative exhibit, University of Wisconsin pharmacologists and anesthetists will collaborate with similar groups from the University of California in a demonstration of modern anesthesia.

An unusual cancer exhibit, which will illustrate the steps being taken to check this most dreaded of all diseases, will have the coöperation of the American College of Surgeons and other noted groups. Use of radium, x-ray, and surgical treatment will be demonstrated as well as modern preventive measures.

Other important subjects to be covered by the American College of Surgeons include the treatment of bone injury, particularly the new plastic bone surgery. Directing the American College of Surgeons' activities at the Exposition will be a committee composed of Dr. Howard Naffziger of the University of California, president-elect of the Association; Dr. Frank Lynch, also of the University of California, vice-president; Dr. Emile Holman of Stanford University; and Dr. Malcolm McEachern of Chicago.

The story of teeth and their connection with general health will be vividly portrayed in the Hall of Science by the exhibit of the American Dental Association. As a central feature of these booths a moving model will demonstrate in a novel way how teeth are formed and grow in the mouth. A series of illustrations will also show how apparently healthy teeth can decay and how many dental troubles can be prevented from spreading to other parts of the body, particularly the heart, kidneys, and bones. Of especial interest to the layman will be a portrayal of the history of dentistry from its earliest beginnings. The crude methods of the ancient man of brawn will be vividly contrasted with the technique of the skilled specialists of today.

Another phase of the Health and Science show will deal with the prevention of diseases transmitted from household pets and other animals to man, such as tuberculosis, rabies, and Malta fever. This section of the Exposition will be under the direction of the American Veterinary Medical Association. Prevention and treatment of disease in animals also will be included in this section of the Hall, which will be under the direction of Dr. C. M. Haring of the Veterinary Science Department of the University of California.

In still another section of the vast Hall of Science industrial chemical companies will show the contributions of modern chemistry in scientific nutrition with all its import to the health of man. Other displays by the chemical industry will show the development of synthetic plastics, compounds which are beginning to be of great importance in improving man's comfort and industrial efficiency.

From the viewpoint of the layman, the medical exhibits of the San Francisco Fair will show how the application of precautionary measures can help prevent the inception of disease and the spread of infection. Every field of medicine is being drafted to help carry out this ambitious program.

For additional information, address Golden Gate International Exposition, 585 Bush Street, San Francisco.

PROPOSED INITIATIVE: MEDICINE AND SURGERY*

Proposed Initiative Law: Sponsors Hoping to Place Same on 1938 State Election Ballot

The *Attorney-General has entitled and summarized the chief purposes of the proposed amendment and the points of such* as follows:

Medicine and Surgery—Initiative.—Defines "practice of medicine" as use or prescription of poisonous drugs or medicinal preparations in treating human ailments, and remedying results of violence of accident by other than orthopedic surgery, excluding from definition all other healing practices. Provides penalties for unnecessary major surgery and creates conclusive presumption that surgery unnecessary if diagnosis is erroneous or no pathology is found justifying operation. Creates conclusive presumption of unskillfulness if person operating has less than five hundred hours' academic surgical training or has taken part in less than fifty major operations. Requires prescriptions be written in English language.

* * *

The people of the State of California do enact as follows:

PUBLIC HEALTH LIABILITY ACT

An Act to protect the public health by providing terms and conditions upon which major surgery may be performed and upon which prescriptions for any substance for treatment of human beings may be issued and dispensed; providing liabilities for the advising of or the performing of unnecessary or unskillful major surgical operations on human beings; defining major surgery and minor surgery, and practice of medicine requiring reports following major surgical operations; repealing all acts or parts of acts in conflict herewith. Provides penalties for violation of Act.

Section 1. This Act *shall be known and cited as the "Public Health Liability Act."*

Sec. 2. It shall be *unlawful for any person to perform any unnecessary major surgical operation upon any human being* or to sever any tissue of a human being unnecessarily, or to advise or prescribe for any unnecessary major surgical operation or the unnecessary severance of any tissue of a human being.

Sec. 3. *An unnecessary major surgical operation* is conclusively presumed where no pathology is found to exist which would justify a major surgical operation as performed, or a major surgical operation performed in pursuance of a wrong diagnosis, or a major surgical operation performed from which the patient could not reasonably be expected to receive the relief of disorder upon which the operation was promised.

Sec. 4. It shall be *conclusively presumed that a major surgical operation was unskillfully performed* unless the person so performing the said operation has had at the time of performing the said operation not less than five hundred hours of training in the subject of major surgery in a duly chartered college of healing; or, who at the time of the adoption of this Act attended and took part in not less than fifty major surgical operations prior to adoption of this Act; or if from the results of the said operation it is proved that the person performing the said operation did not have the necessary skill or training requisite to perform such an operation.

Sec. 5. *Nothing in this Act shall be construed as justifying any person for the negligent performance of any major surgical operation* regardless of skill or training.

Sec. 6. *A wrong diagnosis* is hereby defined to be a wrong conclusion relative to a major surgical procedure, or a wrong conclusion respecting the nature or character of the patient's condition, or a wrong determination of the existing pathology in the patient.

Sec. 7. *The burden of proof of proper training,* experience, skill and diagnosis shall be upon the person performing the said operation as a matter peculiarly within the knowledge of the said person.

Sec. 8. *Before performing any major surgical operation,* the person advising, if he is not to personally perform the said operation, and in any case the person who is to perform the said operation shall sign a written diagnosis of the patient's condition and the necessary purpose of the proposed operation in detail and shall deliver a copy of the said diagnosis and purpose of the proposed operation to the patient or his designated representative. The said writing shall be fully descriptive, definite, and certain. Any waiver or modification of this provision shall be void.

Sec. 9. *Immediately following the performance of any major surgical operation,* and in not more than five days thereafter, the person performing the said operation shall forward all, and each and every part, of excised normal or pathological tissue removed from the patient in the said operation to the State Department of Public Health, together with a copy of the surgical record. It shall be the duty of the said State Department of Public Health to examine the said tissue and to make a full and complete laboratory and other indicated report of findings from the specimens and tissue received. The making of a false report, or the making of an incomplete report as required herein shall be a violation of the Act. The report herein required shall be delivered to the patient or any designated representative in not more than twenty days after receipt of the said tissue, and there shall be no charge for the said report beyond the actual cost thereof.

Sec. 10. The said *Department of Public Health shall retain the said tissue in proper state of preservation* for a period of three hundred days unless that at any time before disposal of the said tissue or specimens on written demand, it shall deliver the same to any laboratory designated by the patient or his authorized representative. The patient may have a professional representative present during the examination of the aforesaid tissue by the said Department of Public Health.

Sec. 11. *Provided, however, that where it appears that an emergency exists* in fact the provisions of Section 8 shall not need be complied with prior to the operation, but that the said diagnosis shall be filed within forty-eight hours after the said operation has been performed. An emergency is defined to be the result of a traumatism or a condition existing that could not normally be calculated upon. Provided further, that, where this emergency provision is proved to have been used as a subterfuge to avoid

* For further comment concerning this proposed law, the sponsors of which are seeking approval from Public Health Committees of Chambers of Commerce and other organizations, see in this issue, on page 5.

The copy of this Initiative came into our hands as the manuscripts for the January issue of CALIFORNIA AND WESTERN MEDICINE were going forward to the printer. For the information of California Medical Association members the letter which was received by members of the Public Health Committee of the Los Angeles Chamber of Commerce is printed below. In the text of the Initiative, the italics have been inserted by the Editor, to permit easier reference.† Letter to the committee members follows:

LOS ANGELES CHAMBER OF COMMERCE

Los Angeles, California,
December 16, 1937.

To All Members of the Public Health Committee,
Los Angeles Chamber of Commerce.
Dear Committee Member:

A special meeting of the Public Health Committee will be held at 12:15 p. m. on Wednesday, December 22, at the Los Angeles Chamber of Commerce, for the purpose of discussing the Public Health Liability Act, Initiative Petition No. 29.

Mr. Frank W. Walden has been invited to meet with the committee at this time, as well as a number of other interested individuals.

This is an important matter, and I hope that all committee members will be present.

Very sincerely yours,
LOS ANGELES CHAMBER OF COMMERCE.
Geo. H. Cecil,
Secretary, Public Health Committee.

† Later memo: On Wednesday, December 22, the Public Health Committee of the Los Angeles Chamber of Commerce voted to recommend nonapproval of this proposed initiative law.

any other provision of this Act, the liability and penal provisions of this Act may be doubled in the sound discretion of the court and within the provision of the law appertaining.

Sec. 12. *Major surgery is defined* as that form of surgery in which it is necessary to penetrate healthy tissue in order to reach morbid or diseased tissue. Morbid tissue shall be understood to include fractures or injured tissue due to traumatism.

Sec. 13. *Minor Surgery is defined* as that form of surgery in which it is not necessary to penetrate healthy tissue in order to reach morbid or diseased tissue. It shall be understood that penetration of healthy tissue when such penetration is limited to the subcutaneous shall be within minor surgery.

Sec. 14. The *practice of medicine is defined* to be the use or prescription of drugs or what are known as medicinal preparations for human beings and those things that are incidental thereto; and remedying as far as possible the results of violence and accident by other than orthopedic surgery, all other practices are declared not to be within the practice of medicine.

Sec. 15. The *term "drug" is defined* to mean any substance, vegetable, animal, or mineral, simple or compounded, in the composition of medicine or what are known as medicinal preparations.

Sec. 16. *"Medicine" or what are known as "medicinal preparations" is defined* to mean any drug or combination of drugs applied, prescribed, or to be used for the purpose of curing, mitigating, or alleviating physical or mental disease of human beings. The application, prescription or use of nonpoisonous substance, vegetable or animal, simple or compounded, shall not be construed as medicine or what are known as medicinal preparations, oils, liniments, or aromatics used for external purposes, shall not be construed to be medicine or what are known as medicinal preparations.

Sec. 17. *Every person who takes part in or assists,* in any manner whatsoever, in any unnecessary surgery as herein set forth, shall be equally liable as a principal, except that any nurse or student nurse having no knowledge of the lack of necessity of the said operation shall be relieved of all liability as herein provided; every hospital or institution, or hospital or institutional corporation, charitable or otherwise, which permits any unnecessary operation as herein defined, in its hospital or institution, shall be equally liable as a principal.

Sec. 18. *That every person, institution, hospital, institutional or hospital corporation,* violating any of the provisions of this Act *shall be civilly liable for the actual damages suffered and an additional sum of $500.*

Sec. 19. *It shall be unlawful for any person to issue a prescription* for any substance for any disease, deformity, or mental or physical condition of any human being, whether such substance shall be what are known as drugs or medicinal preparations or otherwise, *in other than the English language,* or to use or dispense any such prescription unless reduced to writing in the English language; or to issue or dispense any substance under a prescription which does not contain upon the container thereof a label setting forth a copy of the prescription in full, and if the said prescription be for what is known as a patent medicine, the label shall state "this prescription is for a patent medicine" and the name of the patent medicine. Nothing in this section shall be construed to prohibit the use of a language other than English, when made in addition to the English language and constituting a fair interpretation thereof.

Section 20. Any action under the provision of this Act shall be commenced within one year of the time the liability was incurred.

Sec. 21. *In the event that any person convicted under the provisions of this Act is licensed to practice any of the professions characterized as a healing art,* the board or boards of examiners of any such healing art shall suspend the license to practice of the person so convicted for not less than six months, nor more than two years. It shall be a violation of this Act for such person to practice during such suspension.

Sec. 22. *Any violation of the provisions of this Act shall constitute a misdemeanor and shall be punished by imprisonment in the County Jail for a period of not more than six months, or by a fine of not more than $500, or by both such fine and imprisonment.*

Sec. 23. All Acts or parts of Acts in conflict therewith are hereby repealed.

Sec. 24. Any section, subsection, sentence, clause or phrase of this Act for any reason held to be unconstitutional, such decision shall not affect the validity of the remaining portions of this Act. The people hereby declare that they would have passed this Act, and each section, subsection, sentence, clause or phrase thereof, irrespective of the fact that any one or more sections, subsections, sentence, clause or phrases may be declared unconstitutional.†

INFORMATION CONCERNING NEW LABORATORY LAW*

1. A *clinical laboratory* is any place or establishment where any tests, no matter how limited in variety, are made for the investigation of the existence or progress of disease.

2. A *technologist* is a person who directs a laboratory and who holds a license as a technologist.

3. A *technician* is a person who holds a license as technician and who works under the direction of a technologist or of a licensed physician and surgeon.

4. After January 1, 1938, no one may conduct a clinical laboratory unless he is either a technologist or a licensed physician and surgeon.

5. After January 1, 1938, no one may work in a clinical laboratory unless he is a technologist, a technician, or an apprentice.

6. A person may acquire a license as a technologist without examination, provided he has had five years' experience actually directing and at the same time working in clinical laboratories, all of which were completely equipped for, and doing work in all of the sciences of bacteriology, serology, biochemistry, parasitology and related subjects, the last year of which immediately preceding the passage of the Act must have been in California, and provided further that he makes application for the license before January 1, 1938.

7. A technologist's license may be secured by examination, further requirements being that he hold a bachelor's degree in one or more of the fundamental sciences pertaining to laboratory work, from a recognized institution and that he also possess five years' experience, one year of which has been as chief technician in a laboratory, all laboratories being of grade and standard acceptable to the Board of Public Health.

8. Certificates of licensure for clinical laboratory work of limited range will be issued without examination as provided in Section 4 of Chapter 804, to persons presenting evidence of experience in any phase of clinical laboratory work, totaling three years, had within the period of five years immediately preceding the effective date of the Act, one year of which shall have been in laboratories within the State of California. Such certificates will be issued one for each of the general divisions of the work, *i. e.,* bacteriology, serology, biochemistry, and hematology, and in special and particular instances may be issued for still more limited fields of activity, in which case the certificate will set forth particular tests that may be practiced.

The certificates issued under this provision will carry the statement that the license is issued without examination, under the provisions of Section 4 of the law. Graduates of a university recognized by the Board, who hold the A. B. degree, secured with a major in one of the medical sciences, will be credited with the first two years of the required experience, but one year's practical experience in an acceptable laboratory in California must be shown.

Application for technicians' licenses without examination must be made before January 1, 1938.

The fee for a technician's license without examination is one dollar, payable with application. The fee will be returned if the application is rejected.

9. Certificates will be issued to technicians by examination, each certificate entitling the holder to receive a license permitting him to engage in the work covered by the certificate.

† This proposed amendment does not expressly amend any existing law; therefore, the provisions are new provisions added to existing law.

* Chapter 804, California Statutes of 1937.

Besides separate certificates in bacteriology, serology, biochemistry, and parasitology, one all-inclusive certificate, called Senior Clinical Laboratory Technician, will be issued by examination, which certificate entitles its holder to be licensed to engage in all the work of a clinical laboratory.

10. All persons believing themselves eligible to receive any sort of license without examination should immediately write to the State Division of Laboratories, Berkeley, requesting forms on which to apply for the license. Owing to the short time remaining before January 1, where it appears impossible to complete the necessary investigation preliminary to the issuance of a license, a temporary license revocable at any time will be issued.

Such temporary licenses must be replaced by permanent licenses before July 1, 1938.

11. Fees. (Rule 14 of regulations.)

(a) *Clinical Laboratory Technologists.*—The fee for the certificate of license as clinical laboratory technologist shall be $10, payable with application for license without examination. If the applicant is found ineligible, the fee will be returned. The fee for examination for the certificate as clinical laboratory technologist shall be $5, payable with application, and not returnable in case of failure. If the applicant passes, an additional $5 must be paid before the certificate is issued. The annual renewal fee for license as clinical laboratory technologist shall be $10 for each year following the calendar year in which the certificate was issued, and payable within sixty days after the commencement of each calendar year.

(b) *Senior Clinical Laboratory Technicians.*—The fee for the examination and the certificate as senior clinical laboratory technician shall be $5, payable with application, and not returnable in case of failure. The license as senior clinical laboratory technician is good for the remainder of the calendar year in which issued, and must be renewed annually by the payment of a fee of $2 within sixty days after the commencement of each calendar year. A certificate as senior clinical laboratory technician will be issued without examination, but on the payment of the fee of $5, to all persons holding the four certificates of proficiency (Senior Grade in the old series) issued by the Board. In cases where an examination has been paid for in the securing of individual certificates, credit for such payments will apply on the fee for the issuance of the full certificate as senior clinical laboratory technician.

(c) *Certificates of Proficiency.*—These certificates, one in each of the subjects of bacteriology, serology, biochemistry, and parasitology, will be issued by examination in these subjects separately. The fee for the examination in any one subject and for the certificate and license good for the remainder of the calendar year is $2, not returnable in case of failure.

Persons now holding one or more certificates of proficiency will be issued licenses for the activities covered by the certificates which they hold. If an application for license without examination is filed, it may be found possible to include in the license issued other activities not covered by the certificate of proficiency held by the applicant.

A license in parasitology is given only by examination. The license as senior clinical laboratory technician is not given without examination except to holders of four certificates.

12. The law does not require technicians working in a doctor's office to be licensed unless work is done for other doctors or for the patients of other doctors.

13. The exemption of nonprofit hospitals, provided for in Section 6 of the law applies only to hospitals maintained by corporations for the benefit of their own employees, the hospitals being supported by "dues or contributions from employees of a common employer, or a group of affiliated employers. . . ."

14. The renewal fee for certificates of proficiency is fifty cents each, payable annually. A pocket license card is issued upon payment of the fee. Renewals and licenses for 1938 will be ready for distribution early in November.

15. Holders of four certificates of proficiency may exchange them for a senior clinical laboratory technician's certificate, or, if they meet certain other requirements, for a technologist's license.

ELIXIR SULFANILAMIDE—MASSENGILL*

Report of the United States Secretary of Agriculture

During September and October of 1937 at least seventy-three persons died as a direct result of taking the drug known as "Elixir Sulfanilamide." Twenty other persons who took the "elixir" died, but it has not yet been established that this drug was exclusively responsible. The ninety-three deaths occurred in fifteen states, as far east as Virginia, as far west as California.

"Elixir Sulfanilamide" was manufactured and sold by the S. E. Massengill Company of Bristol, Tennessee. According to the firm's books, 240 gallons were manufactured. The entire amount has been accounted for.

Before the "elixir" was put on the market, it was tested for flavor but not for its effect on human life. The existing Federal Food and Drugs Act does not require that new drugs be tested before they are placed on sale.

"Elixir Sulfanilamide" was first distributed commercially on September 4, 1937, and continued to October 15, 1937. The first word of deaths from an unidentified sulfanilamide preparation reached the Food and Drug Administration on October 14. On October 16 an investigator for the Administration telegraphed from Tulsa, Oklahoma, that nine persons had died there after taking "Elixir Sulfanilamide." Seizure of all outstanding shipments was immediately ordered.

Since the Federal Food and Drugs Act contains no provision against dangerous drugs, seizures had to be based on a charge that the word "elixir" implies an alcoholic solution, whereas this product was a diethylene glycol solution. Had the product been called a "solution," rather than an "elixir," no charge of violating the law could have been brought.

Of the 240 gallons manufactured, 228 gallons and 2 pints have been seized under federal and state laws, destroyed, collected as laboratory samples, or wasted by spillage and breakage. Eleven gallons and six pints were dispensed on prescriptions or over-the-counter sales. Of this amount, about half was consumed and caused the deaths; the other half was retrieved before consumption.

The lethal effect of the "elixir" was due to its content of diethylene glycol, which was used as a solvent in making a liquid preparation of sulfanilamide, usually administered in tablet or powder form. Sulfanilamide itself is a valuable drug, and was not responsible for the disaster.

Sulfanilamide is the name of one of a group of closely related chemicals first reported in European medical literature of 1935 to have been used for drug purposes. It has shown dramatic curative effects. Physicians in this country have been quick to recognize its far-reaching possibilities. Its use has grown to tremendous proportions. An editorial from the *Journal of the American Medical Association* stated that sulfanilamide is potentially dangerous, but that properly used it may be brilliantly successful in treating various infections.

The fatal "elixir" was rushed onto the market without adequate test to determine whether or not diethylene glycol may be safely used as a solvent for sulfanilamide, despite previously published reports in scientific literature showing that diethylene glycol might be dangerous when taken internally. A few simple and inexpensive tests on experimental animals would have quickly demonstrated the toxic properties of both diethylene glycol and the "elixir."

It will be observed that the preparation is a semi-secret one, that the presence of diethylene glycol is not disclosed, and that no warning of danger appears.

Most of the drug was administered on physicians' prescriptions.

HOW THE "ELIXIR" WAS PRODUCED

For some time before putting "Elixir Sulfanilamide" on the market, the S. E. Massengill Company had been marketing sulfanilamide in capsule and tablet form. In June, 1937, the firm's salesmen reported a demand for the drug in liquid form. Near the end of July, Mr. Watkins,

* Submitted to Congress at Washington, D. C., in response to House Resolution 352 of November 18, 1937, and Senate Resolution 194 of November 16, 1937.

See also editorial comment in December CALIFORNIA AND WESTERN MEDICINE, on page 366. For list of United States Senators and Representatives, to whom letters may be sent, in favor of revision of Federal Food and Drug laws, see in this issue on page 71.

chief chemist of the Massengill Company, according to his own statement, undertook the problem of finding a suitable liquid vehicle for sulfanilamide. Since sulfanilamide is insoluble in the various liquids commonly employed in making medicines, he tried a number of other solvents. Diethylene glycol was found to dissolve as much as 75 grains of sulfanilamide per fluidounce, but in that concentration it tended to separate out on chilling. Accordingly he decided upon 40 grains per fluidounce as a stable preparation and devised the following working formula:

Sulfanilamid	58½ pounds
Elixir Flavor	1 gallon
Raspberry Extract	1 pint
Saccharin Soluble	1 pound
Amaranth Solution 1-16	1½ pints
Caramel	2 fluidounces
Diethylene Glycol	60 gallons
Water q. s.	80 gallons

According to Mr. Watkins no tests were made to determine the toxicity of either the separate ingredients or of the finished product, or to determine by well-known methods available for the purpose whether or not the sulfanilamide decomposed in the diethylene glycol. The so-called control laboratory merely checked the "elixir" for appearance, flavor, and fragrance. Doctor Massengill confirmed Mr. Watkins' statement that no experimental animals were used or clinical tests of any kind made to determine either the effectiveness or the toxicity of the drug before it was put on the market.

THE FOOD AND DRUG ADMINISTRATION STEPS IN

The first word of deaths from an unidentified sulfanilamide preparation reached the Food and Drug Administration on October 14, 1937, through a telephone call from a New York physician associated with a large drug manufacturing concern. He repeated advices, presumably received through professional or trade contacts, that fatalities had occurred at Tulsa, Oklahoma.

Immediately instructions to investigate the report were issued by telegraph to the Kansas City station of the Food and Drug Administration, which is the nearest station to Tulsa. A representative of the Administration arrived in Tulsa the following day. He reported by telegraph on Saturday, October 16, that nine deaths had already occurred in Tulsa, including eight children with streptococcic sore throat and one adult with gonorrhea, and that all had taken a product labeled "Elixir Sulfanilamide. The S. E. Massengill Company, Manufacturing Pharmacists, Bristol, Tennessee."

Shipping records showed that the suspected "elixir" had come from a Massengill establishment in Kansas City, to which the station immediately sent inspectors. Also an inspector from the Cincinnati station, which is the nearest station to Bristol, and a medical officer from the Administration's headquarters at Washington, were sent at once to Bristol.

It was found that some of the "elixir" had been made at the Kansas City branch factory and that supplies had been sent to the New York and San Francisco sales branches. Immediately inspectors from the New York and San Francisco stations were assigned to investigate distributions from these points.

It was learned that the Massengill Company, following reports of the poisonous effects of the "elixir," had sent out approximately 375 telegrams from Bristol and additional telegrams from its branch houses totaling, according to the firm's statement, some 1,100 in all, requesting the return of outstanding shipments.

On or about October 15, on telegraphed instructions from the Bristol office, the San Francisco branch of the firm instructed its salesmen to have outstanding stocks returned. However, investigation revealed that no attempt had been made by that branch to communicate directly with dealers and doctors.

The telegrams and letters sent out by the Massengill Company gave no indication of the dangerous character of the product and were not calculated to impress receivers with the emergency character of the call for returning the goods, the inspector assigned to the Bristol office insisted that the firm issue the following telegram, dated October 19, to all persons who were listed as having received shipments of the "elixir" from Bristol:

> Imperative you take up immediately all Elixir Sulfanilamide you dispensed. Product may be dangerous to life. Return our expense.

Following similar insistence by the San Francisco, Kansas City, and New York inspectors, the branches at those points sent the following or similar telegrams to all consignees, on or about October 19:

> Imperative you take up immediately all Elixir Sulfanilamide you may have dispensed. Product may be dangerous to life. Return all stocks our expense.

As a result of these telegrams large quantities of the "elixir" was returned to the manufacturer's establishments and there taken under local or federal control. But the extremely dangerous character of the drug necessitated the most searching check to guarantee, as far as humanly possible, its complete apprehension. Practically the entire field force of 239 Food and Drug Administration inspectors and chemists were assigned to the work. They had the wholehearted and effective coöperation of state and local food, drugs, and health authorities. As an additional aid, warnings by newspaper and radio were broadcast.

In spite of the manufacturer's telegrams many shipments were found still in dealers' hands. Innumerable prescriptions filled from these lots, as well as from shipments returned to the manufacturer, were found to have been only partly consumed by the patient and so were recovered.

EFFECTS OF THE DRUG

The victims of the "elixir" were ill from about seven to twenty-one days. They suffered intense pain. All exhibited very much the same symptoms: stoppage of urine, severe abdominal pain, nausea and vomiting; stupor; convulsions preceded death in some cases. Many persons who took the drug discontinued its use with the onset of unfavorable symptoms and recovered. One person took as much as seven and one-half fluidounces without ill effect. One child died from less than two fluidounces.

LIMITATIONS OF THE LAW

As indicated earlier in this report, the only basis of action under the Food and Drugs Act against the interstate distribution of the "elixir" was the allegation that the word implies an alcoholic solution, whereas the product was a diethylene glycol solution. The fact that the law contains no specific definition of "elixir" may be responsible for Doctor Massengill's statement in his letter to the American Medical Association, carried in the press of November 3: "I have violated no law."

Most drug manufacturers recognize a responsibility to the public far greater than that imposed by existing law. Some are known to have considered making a solution of sulfanilamide in diethylene glycol before the "elixir" was put on the market, but abandoned the idea on investigating the toxicity of the solvent. But the attitude of some drug makers is exemplified in Doctor Massengill's statement carried by the press on October 23:

> My chemists and I deeply regret the fatal results, but there was no error in the manufacture of the product. We have been supplying legitimate professional demand and not once could have foreseen the unlooked-for results. I do not feel that there was any responsibility on our part. The chemical sulfanilamide had been approved for use and had been used in large quantities in other forms, and now its many bad effects are developing.

That evidence of possible danger from the internal administration of diethylene glycol was available prior to the marketing of the "elixir" is easily shown.

That a few simple tests on experimental animals would have demonstrated the lethal properties of the elixir is evident from the work reported by the American Medical Association. These results were confirmed independently by the Division of Pharmacology of the Food and Drug Administration in work yet unpublished.

While the "elixir" incident has been spectacular and has received much publicity, aside from the brevity of the period in which the killings occurred, it is but a repetition of what has frequently happened in the past in the marketing of such dangerous drugs as dinitrophenol, cinchophen, and other toxic substances.

It is worthy of note that, shocking as these instances have been, the actual toll in deaths and permanent injury from potent drugs is probably far less than that resulting from harmless nostrums offered for serious disease conditions. In these cases the harmful effect is an indirect one.

Sick people rely on false curative claims made for worthless concoctions, and thus permit their disease to progress unchecked. It may be too late when they lose confidence in the nostrum and seek rational treatment.

RECOMMENDATIONS FOR LEGISLATION

To protect the public from drugs which, like the "elixir," are dangerous because of their inherent toxicity, it is the Department's recommendation that legislation be enacted to provide at least the following:

1. License control of new drugs to insure that they will not be generally distributed until experimental and clinical tests have shown them to be safe for use. The definition of what constitutes a new drug should include (*a*) substances which have not been used sufficiently as drugs to become generally recognized as safe, (*b*) combinations of well-known drug substances where such combinations have not become generally recognized as safe, and (*c*) well-known drug substances and drug combinations bearing label directions for higher dosage or more frequent dosage or for longer duration of use than has become generally recognized as safe.

Exemption should be made for new drugs distributed to competent investigators for experimental work. A board of experts should be provided who will advise the Secretary of Agriculture on the safety of new drugs.

It is the Department's view that no other form of control will effectively safeguard the public from the dangers of premature distribution of new drugs. To increase the penalties for violations and to require label disclosure of ingredients would be helpful, but by no means fully adequate.

In the interest of safety, society has required that physicians be licensed to practice the healing art. Pharmacists are licensed to compound and dispense drugs. Electricians, plumbers, and steam engineers pursue their respective trades under license. But there is no such control to prevent incompetent drug manufacturers from marketing any kind of lethal potion.

2. Prohibition of drugs which are dangerous to health when administered in accordance with the manufacturer's directions for use. This would provide a more appropriate basis of action than that on which proceedings were instituted against the "elixir." A number of dangerous drugs are now on the market against which not even a trivial charge of violation can be made.

3. Requirement that drug labels bear appropriate directions for use and warnings against probable misuse. Much injury results from insufficient directions and from lack of warning against overdosage, or administration to children, or use in disease conditions where the drug is dangerous, or possibility of drug addiction.

4. Prohibition of secret remedies by requiring that labels disclose fully the composition of drugs. Many foreign countries now impose this requirement. Many drugs manufactured in the United States are exported to such countries under labels bearing such disclosure. The same drugs are sold to our citizens under labels that give no hint of their composition.

The physician, and the consumer who acts as physician to himself, both have a right to know what they administer.

Many poisoning cases result from choice of the wrong bottle from the home medicine cabinet, or from bottles left within the reach of small children. In such cases attending physicians are able to proceed intelligently and administer the proper antidotes or other treatment only if labels carry full disclosure of composition. Delays in obtaining this information by communicating with the manufacturer may often mean the difference between life and death.

Physicians are also handicapped in arriving at a correct diagnosis and beginning appropriate treatment when patients come to them after unsuccessful attempts at self-medication with secret remedies. The effect of such remedies may give rise to symptoms leading to erroneous diagnosis. But even if the diagnosis is correct, the kind of treatment to be used may depend upon what the patient has been taking. Again, in such circumstances, label declaration of composition may mean the difference between life and death.

The foregoing recommendations are limited to provisions which the Department believes should be enacted to safeguard the public from the dangers of drugs of one type. That type includes the inherently toxic drugs, such as the "elixir," dinitrophenol, and cinchophen. Many additional points should be considered if adequate protection is to be extended against even more widespread dangers to health and other abuses of public welfare arising from the inadequate control authorized by the present law over various other types of drugs.

PUBLIC HEALTH IS MAJOR EFFORT OF FEDERAL FOOD AND DRUG ADMINISTRATION*

Control of food and drug adulterations having a direct bearing on public health continued to require the major efforts of the Food and Drug Administration in the last fiscal year, according to the annual report of W. G. Campbell, Chief of the Administration.

Mobilization of an emergency force to follow the 1937 flood in the Ohio Valley and protect residents from food contaminated by flood waters was one of the conspicuous services by the Food and Drug Administration in the last year. Many of the forty-four federal food men assigned to the work had had experience in the 1936 flood. They were assisted by about eighty men from state and city food inspection organizations and from other federal agencies. The emergency organization functioned promptly. Work programs were under way in some areas before the flood waters began to recede. These crews handled food and drug preparations enough to have supplied a city of two hundred thousand population for a full year.

Another emergency requiring quick action by many field employees arose when it was discovered that emergency fumigation with hydrocyanic gas had made dangerous a quantity of raisins and other dried fruits—about 280,000 pounds—held up at the shipping point during the maritime strike and that these had been widely distributed. Food and Drug Administration workers quickly traced and seized nearly all the contaminated food, and the use of this method of fumigation for these commodities was immediately discontinued.

FINES VARY WIDELY

Mr. Campbell comments on the 1,700 court cases terminated in the year—1,355 food cases and 345 drug cases. "Fines varied," he says, "from sums as low as $1, $2, and $5 to a maximum actually paid of $1,500. Much higher fines were imposed in several cases, but were remitted in large part by the courts. Three jail sentences imposed in connection with second offenses were also suspended and the defendants placed on probation. In pleas of guilty to the adulteration of olive oil with tea-seed oil, two defendants were each fined $6,000, but $5,000 was subsequently remitted in each case.

"Courts in general vouchsafed no explanation for the imposition of nominal penalties. In one instance of a $2 penalty for the shipment of filthy and decomposed walnuts, the court indicated that it had taken into consideration the fact that the defendant had suffered a $1,400 loss in the seizure and destruction of the shipment by the Government. In another instance dealing with a practically worthless product offered as a treatment for serious diseases of the eye, the court imposed without comment, a fine of $1 and costs of $35."

"Other courts," Mr. Campbell continues, "have indicated a growing interest in the public protection afforded by the Food and Drugs Act. In passing sentence against a spinach canner who had entered a plea of guilty to the sale of dirty canned spinach, a court remarked that if the defendant was unable to manufacture clean food he had better get out of business and stay out of that court."

ISSUES IN LEGISLATION

Discussing possible changes in the law, Mr. Campbell says: "As in the three preceding years, legislative efforts have been continued in the Congress for a more adequate food and drug law. Senate Bill 5, introduced January 6, 1937, was passed by the Senate on March 9. This bill pro-

* From the United States Department of Agriculture.

poses a comprehensive revision of the Food and Drugs Act. Other bills of similar character are H. R. 300 and H. R. 5286. H. R. 5286 is designed to amend the Federal Trade Commission Act by authorizing specific control under that Act of false advertising of foods, drugs, therapeutic devices, and cosmetics.

"At the close of the fiscal year all these measures were pending before the House Committee on Interstate and Foreign Commerce. The principal issues involved were:

"1. Should seizure action to prevent distribution to consumers of a misbranded product be limited, pending court trial of the case, to a single interstate shipment of that article, or should the authority in the present law to seize all such shipments be continued?

"2. Should seizure cases be tried, as at present, where the goods are seized, before the courts and juries of the consuming areas where the goods are intended for distribution, or should the law be changed to authorize the case to be removed to the place from which the goods were shipped and there tried before the courts and juries of producing areas?

"3. Should the misbranding provision of the present law, which prohibits labeling that is 'false or misleading in any particular' be retained, or should the standard of truthfulness thus imposed be changed to ban labels only when 'misleading in a material respect'?

"4. Should false advertising of foods, drugs, therapeutic devices, and cosmetics be controlled through injunctions and cease-and-desist orders, which carry no penalty for the initial offense or for subsequent offenses up until the date the injunction or order becomes effective, or should a deterrent to the commission of these offenses be set up by providing penalties for their initial commission?"

ENFORCEMENT OF ACT

As compared with 1936, the Administration collected more samples of food and drugs, but there were slight decreases in the totals of the criminal prosecutions and seizures. Improvement in foreign trade was reflected in an increase in the number of import samples and in time devoted to imports.

The spray residue situation has improved materially, largely because many states now meet fully the federal standards and are controlling poisonous spray residues on fruits and vegetables before the products leave the State. Federal workers analyzed more than 5,000 samples of fresh fruits and vegetables, but on incomplete returns State laboratories are known to have made more than 85,000 tests.

"Continuing the good record of several years, no authentic case of botulism from American commercially canned food was reported," says Mr. Campbell.

Both the salmon and tuna packs required considerable control last year, but the sardine and mackerel packs gave no reason for seizures. The Administration and the salmon-packing industry have worked out a new method for simplifying the control of the pack and making it more effective.

Adulteration of food with water is one of the most profitable forms of economic cheats, and one of the hardest to deal with, says the report, emphasizing the need for legal standards to establish limits on the water content of canned and bottled products.

The Administration tested the vitamin D value of nearly 900,000 gallons of imported oils—principally cod-liver oil, intended for animal feeding. About one-third was deficient in vitamin value and was excluded. In interstate tests of vitamin products, twenty-four out of thirty-four samples failed to show the vitamin values claimed for them.

Conditions are improving notably, but the campaign for cleaner cream and butter will have to be continued, the report says. It also includes records of the enforcement of several minor acts administered by the Food and Drug Administration that regulate insecticide, caustic poisons, import milk, filled milk, naval stores, tea imports, and the certification of coal-tar colors.

UNITED STATES SENATORS AND REPRESENTATIVES IN CONGRESS: FOR CALIFORNIA

With Special Reference to Federal Pure Food and Drug Law

For the information of county society secretaries and members of the California Medical Association who desire to write to the two United States Senators from California and to the Representatives from their own and other districts, the roster of congressmen is given below.

While Congress is in session, as at the time of this writing, these congressmen may be addressed as follows:

Hon. ————————
Senator for California
(or Congressman for California)
Washington, D. C.

California and Western Medicine, in its December issue, on pages 366 and 435, discussed the Federal Food and Drug laws. County societies were urged to write to congressmen. The roster below may be of service.

UNITED STATES SENATORS AND REPRESENTATIVES IN CONGRESS

United States Senators

Hiram W. Johnson (Rep.), Mills Tower Building, San Francisco.

William G. McAdoo (Dem.), Transamerica Building, Los Angeles.

Represenatives in Congress

Clarence F. Lea (Dem., Rep.), 719 North Street, Santa Rosa, First District.

Harry L. Englebright (Rep., Dem.), Nevada City, Second District.

Frank H. Buck (Dem.), Vacaville, Third District.

Franck R. Havenner (Prog.), 640 Ellis Street, San Francisco, Fourth District.

Richard J. Welch (Rep., Dem., Prog.), 978 Guerrero Street, San Francisco, Fifth District.

Albert E. Carter (Rep., Dem., Prog.), 552 Montclair Street, Oakland, Sixth District.

John H. Tolan (Dem.), 1007 Harvard Road, Oakland, Seventh District.

John Joseph McGrath (Dem., Rep., Prog.), 280 Crystal Springs Road, San Mateo, Eighth District.

B. W. Gearhart (Rep., Dem.), 857 M Street, Fresno, Ninth District.

Henry E. Stubbs (Dem.), 707 East Cypress, Santa Maria, Tenth District.

John Steven McGroarty (Dem.), Tujunga, Eleventh District.

H. Jerry Voorhis (Dem.), Valley Center, San Dimas, Twelfth District.

Charles Kramer (Dem.), 1947 North Serrano, Los Angeles, Thirteenth District.

Thomas F. Ford (Dem.), 940 North Benton Way, Los Angeles, Fourteenth District.

John M. Costello (Dem.), 2142 Canyon Drive, Hollywood, Fifteenth District.

John F. Dockweiler (Dem., Rep.), 935 South Dunsmuir, Los Angeles, Sixteenth District.

Charles J. Colden (Dem.), 2200 Alma Street, San Pedro, Los Angeles, Seventeenth District.

Byron N. Scott (Dem.), 6325 East Ocean Boulevard, Long Beach, Eighteenth District.

Harry N. Sheppard (Dem.), Box 465 Yucaipa, Nineteenth District.

E. V. Isaac (Dem.), 5380 El Cajon, San Diego, Twentieth District.

Do Not Coddle Diabetic Child, Physicians Warn.—Severe onsets of diabetes in children may be due principally to false notions and neglect in parents, in many instances. Ordinarily, diabetic children under adequate treatment are as healthy otherwise as so-called normal children, and should be treated like others of their age. They should not be singled out by the parents for special coddling or undirected home treatment, nor should they be segregated from other children or adults.

This statement is made by the Division of Pediatrics of the University of California Medical School, in an effort to decrease the disabilities of children during the acute phases of child diabetes generally.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 1, January, 1913

From some Society Reports:

California Northern District Medical Society.—The twenty-second annual meeting was held at Elks Hall, Chico, November 19, 1912. New officers elected: President, Dr. Dan Moulton, Chico; First Vice-President, Dr. G. H. Fay, East Auburn; Second Vice-President, Doctor Peery, Yuba City; Secretary, Dr. F. F. Gundrum, Sacramento; and Treasurer, Dr. O. Stansbury, Chico.

Glenn County Medical Society.—On November 21, a first meeting was called by the physicians of Glenn County for the purpose of organizing a county medical society. Dr. J. A. Randolph was chosen temporary chairman, and Dr. F. M. Lawson temporary secretary.

Our Medical Defense.—

To the Medical Society of the State of California.
Gentlemen:

I wish to thank the Society for the manner in which it looked after the defense of the malpractice suit brought against me by J. F. Beene, who suffered from a delayed union of the radius and ulnar of the left arm. Your defense was thorough and every precaution was taken for the protection of my professional reputation, as well as my finances, and no corporation insurance company or individual could have more surely or successfully cared for and protected my interests.

I wish it were possible for the whole profession to realize the importance of having the Society back of them, as I do. Any physician is just as liable to have a suit brought against him as I was, and no better protection can be had than I got in my recent trial.

Very truly yours,
N. T. Enloe,
Chico, Calif.

From some Editorial Notes:

Proper Reciprocity.—The "Fresno Republican," in its issue for November 21, again discusses the *Journal* of the Medical Society of the State of California and the question of medical reciprocity, and asks, "Will the *Journal* say whether it favors a reciprocity law, such as most other states have, to apply to states having equally high standards?" Most unequivocally, *yes!* Not only does the *State Journal* approve of a *proper* reciprocity law, but the State Medical Society, when it prepared the law of 1901, included in that law a reciprocity clause. Is that sufficient indication of the attitude of the Society and of its *Journal?*

* * *

Progress in Anesthesia.—The last few years have seen considerable progress in the development of improved anesthetics and improvement in the manner of producing anesthesia. It is quite a while since the spectacle of two or three husky men holding one poor patient, while another helper crowded a mask over his face, has faded away. Gwathmey has recently made a suggestion that, during the limited time it has been tried, seems to be a distinct advance in anesthesia. He begins the anesthesia with two to four drops of essence of orange (25 per cent U.S.P.), and then continues with the drop method of ether anesthesia. In a recent paper in the *Journal of the American Medical Association,* he highly commends the work of the Committee on Anesthesia of the Association, and recommends that it be continued. He also suggests that the future development in anesthesia should be along the line of some form of "vapor anesthesia."

* * *

Congresses and Clinics.—The great surgical congress recently held in New York seems, from the accounts of

(Continued in Front Advertising Section, Page 15)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

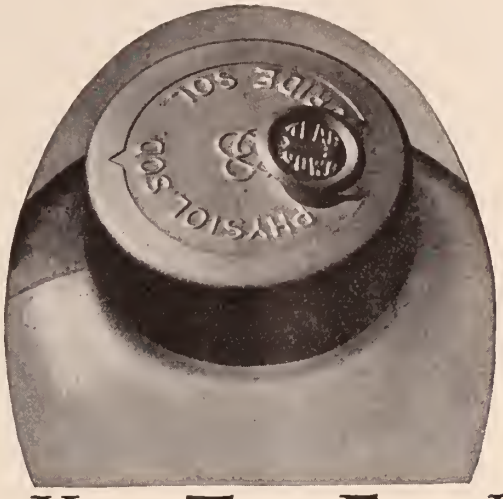
"Los Angeles is America's No. 1 quack nest. This was the declaration of Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association,* yesterday, when he addressed the fourth annual post-graduate assembly of the College of Medical Evangelists. 'It is high time State officials were driving the quacks out of business in Los Angeles,' he said. 'I have been in every city in the United States at least five times in the last two years, and I say without reservation that Los Angeles has more quacks than any other place in the country. This city is full of medical charlatans and mumbo-jumbo practitioners of all kinds. It is up to the State of California to clean up the town.' Doctor Fishbein declared medical quacks are ruining the lives of hundreds of persons every year. 'These fakers, with their lurid promises of cure-alls, are bringing sorrow and tragedy to many of our citizens,' he said. 'I urge the men and women of the medical profession to join the fight to end the widespread quackery in Los Angeles.' Doctor Fishbein addressed one thousand physicians and surgeons in Paulson Hall of White Memorial Hospital. . . ." (Los Angeles *Examiner,* December 6, 1937.) The Annual Reports of the Board of Medical Examiners for many years past verify the statements quoted. For instance, Los Angeles Special Agent Carter in his Annual Report for 1933 said, "Throughout the past year we have made continual effort to prosecute and drive from California various fakers, who, on one pretext or another, prey upon the sick and afflicted. . . . These charlatans come to California from all over the world and, strange as it may seem, they always find some poor sucker who falls for their new discovery, or machine, or method that is heralded as a sure cure for almost every ailment mankind is heir to. Apparently intelligent persons, who would think they were grossly overcharged if a regular physician charged them a $10 fee, will cheerfully pay $250 to $2,000 for a fake 'radium operation' on their eyes by a smooth-talking confidence man, whom they never saw or heard of before. . . ." The number of charlatans is so great and the majority are so well entrenched by astute legal advice, that the four investigators allowed the Board of Medical Examiners find insurmountable difficulties in endeavoring to make an impression on the host referred to. The monthly report of the Board of Medical Examiners, both North and South, speaks for itself as to the continued activities of said Board in endeavoring to protect the citizens of this State from imposition and fraud.

"Richard J. Howard, seventy-one, Hacienda rancher, was lodged in the county jail at Santa Rosa, Wednesday night, on complaint of an inspector for the State Board of Medical Examiners. He is accused of practicing medicine without a license. Arrested as Howard's assistant in what T. P. Hunter, the state investigator, termed a 'quack' cancer cure, was William P. Devine. The state official also seized a supply of patent medicines which he claimed were used by Howard, once widely known throughout Sonoma Valley as 'Doctor' Howard. The arrests were the result of an asserted course of treatment given to an aged Kenwood resident, said to be a cancer sufferer, officers said. . . . Records at the county jail show that Howard has been arrested several times in recent years for asserted violation of the State Medical Practice Act. . . ." (Petaluma *Argus-Courier,* November 11, 1937.) (Previous entries, December, 1929; June, 1932.)

"Surprise is created by the news that a sufferer from disease intrusted his case to a quack rather than to a reputable physician. One naturally wonders why anyone will take chances in a matter of such moment with persons

(Continued in Front Advertising Section, Page 20)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



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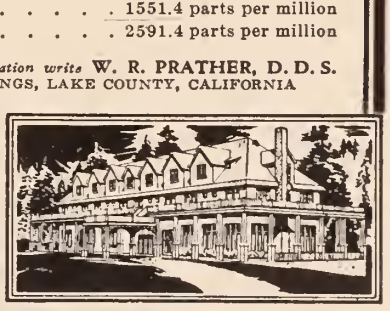
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The first procedure (1a) depends upon the nature of the response to administration of pure vitamin B1. The second procedure, which has been more widely applied, makes use of the Cowgill formula for calculation of vitamin B1 requirement. By consideration of the actual vitamin B1 intake and the calculated vitamin B1 requirement in any specific instance, the probability of mild avitaminosis B1 may be evaluated (1b).

It is difficult to estimate the frequency of mild vitamin B1 deficiencies in the United States. However, until such information is at hand, it is not illogical to suggest that latent avitaminosis B1 must be regarded as an active possibility in some cases which may come to the attention of the medical practitioner. Fortunately, several factors are operative which give assurance that eventually the incidence of latent avitaminosis B1 will be reduced to a minimum.

First, those concerned with human nutrition have today more definite information concerning quantitative human vitamin requirements than ever before in history (2).

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1a. 1935. J. Am. Med. Assn. 105, 1580.
b. 1934. The Vitamin B Requirement of Man, G. R. Cowgill, The Yale University Press, New Haven.

2. 1937. J. Am. Diet. Assn. 13, 195.

3. 1936. J. Nutrition 11, 383.
1934. Ibid. 8, 449.
1932. Ibid. 5, 307.
1932. Ind. Eng. Chem. 24, 457

This is the thirty-second in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The Greatest Menace of All.—During the World War, poison gases were discussed by the average citizen with fear and loathing. Today, newspapers cry war, and frighten us with tales of future gas attacks on our cities, killing men, women, and children. Few who read these news stories realize, however, that carbon monoxid gas is now, and has been since the cave dwellers first discovered fire, the most widespread and treacherous poison connected with human life and activities—treacherous in that it seldom gives warning, being colorless, odorless, tasteless, and non-irritating. Carbon monoxid poisonings were occurring before Babylon had risen. Ancient writers mentioned deaths that were undoubtedly due to carbon monoxid, and in the Middle Ages its activities were ascribed to witchcraft and many women were burned for "hexing" a family that was found dead. Suicides by carbon monoxid generated by carbon braziers became so prevalent in France that frequent references are made to them in the literature of Dumas, Victor Hugo, and Eugene Sue.

Today, deaths from carbon monoxid bow only to automobile fatalities and take second place as the cause of accidental and suicidal deaths.

We rightly hear a great hue and cry concerning the traffic accidents in our country. Everyone knows that there were roughly 36,000 deaths due to traffic accidents in 1935. How many people know, however, that there are roughly 50,000 deaths from asphyxiation in the United States each year, and half of them are due to carbon monoxid! Briefly, by rough comparison, whenever seven people are killed by automobiles, five die of carbon monoxid poisoning. This ratio is further shown by a comparison with accurate sta-

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(Continued from Page 38)

tistics for New York City. There were, in a five-year period (1928-1932), 5,289 carbon monoxid deaths, an average of over 1,000 a year. The number of these accidents was exceeded only by motor-vehicle deaths with an average of 1,400 a year, or again seven for automobiles and five for carbon monoxid.

And carbon monoxid deaths are on the increase! In the article, "Carbon Monoxid Poisoning Makes an Enormous Increase" (Ohio Health News, October 15, 1936), we find that during the year ending September 30, 1936, the number of reported cases of carbon monoxid poisoning in Ohio increased 77 per cent (with 42 per cent increase in deaths) over the preceding year!

Carbon monoxid is not a true poison. Its deadly action is due to asphyxia. It displaces oxygen from the hemoglobin of the blood, thus depriving the vital organs of oxygen. It has been proved by Haldane that carbon monoxid has an affinity three hundred times greater for hemoglobin than has oxygen. Hence, fatal poisoning can quickly overcome the exposed person before he is aware of the danger. Carbon monoxid is rarely found in a free state. It is a product of incomplete combustion of carbonaceous material. The use, therefore, of any form of carbonaceous fuel, such as wood, coal, charcoal, gas, oil, kerosene, and gasoline, is dangerous unless there is an efficient method of drawing off the combustion products. The unflued heating stove is very dangerous. When a gas flame touches cold metal, carbon monoxid is generated, hence instantaneous hot-water heaters are a constant menace. Automobiles are exceptionally efficient generators of carbon monoxid; the average automobile giving off one cubic foot of carbon monoxid every minute for every twenty horsepower.

There is danger of fatal poisoning if air containing as much as one-half of one per cent carbon monoxid is breathed for fifteen minutes and concentrations over 0.2 per cent are dangerous if inhaled over a period of time. Exercise and exertion greatly increase the speed of absorption and hasten collapse.

Carbon monoxid poisonings are usually specified as rapid acute, slow acute, and chronic. Symptoms of acute poisoning vary with the intensity and the amount of carbon monoxid entering the body. In some cases the intensity is so great that the victim becomes unconscious before he is aware of the danger. Here, only immediate rescue can save his life. In other acute cases the victim has warning symptoms, the most common being a severe headache with a sense of throbbing and pressure, particularly in the region of the temples. Other symptoms are dizziness, nausea, sometimes vomiting, pains in the upper abdomen, weakness in the legs, palpitation, disinclination to move, hallucinations, and sometimes mental disturbances and convulsions. Judgment is often impaired and cases have been reported where the victim has refused to leave the gas-filled room and fought with his rescuers.

When the victim becomes comatose he may present one of several pictures. Sometimes he may show pink skin, red lips, and red blotchy skin areas. Again there may be pallor, or again bluish skin (cyanosis). Useless movements of the muscles of the face or arms and legs may occur. Coma may last from a few minutes to several days after rescue, although when it continues more than forty-eight hours it is usually fatal. A positive diagnosis cannot be made, however, on the above-named symptoms. One must get a history of exposure to carbon monoxid. The blood is usually cherry red. Positive diagnosis is based on finding carbon monoxid in the blood. This can be done by a very simple chemical analysis of a drop or so of the blood. This test must be made promptly after rescue, however, since the properly breathing victim exhales about one-half of the carbon monoxid within him during each hour following rescue. The breathing of oxygen gas materially hastens this displacement.

Many after-effects may follow acute carbon monoxid poisoning. Pneumonia sometimes occurs during or after coma, particularly if smoke is breathed at the same time or if the victim is not kept warm. Definite nervous and mental

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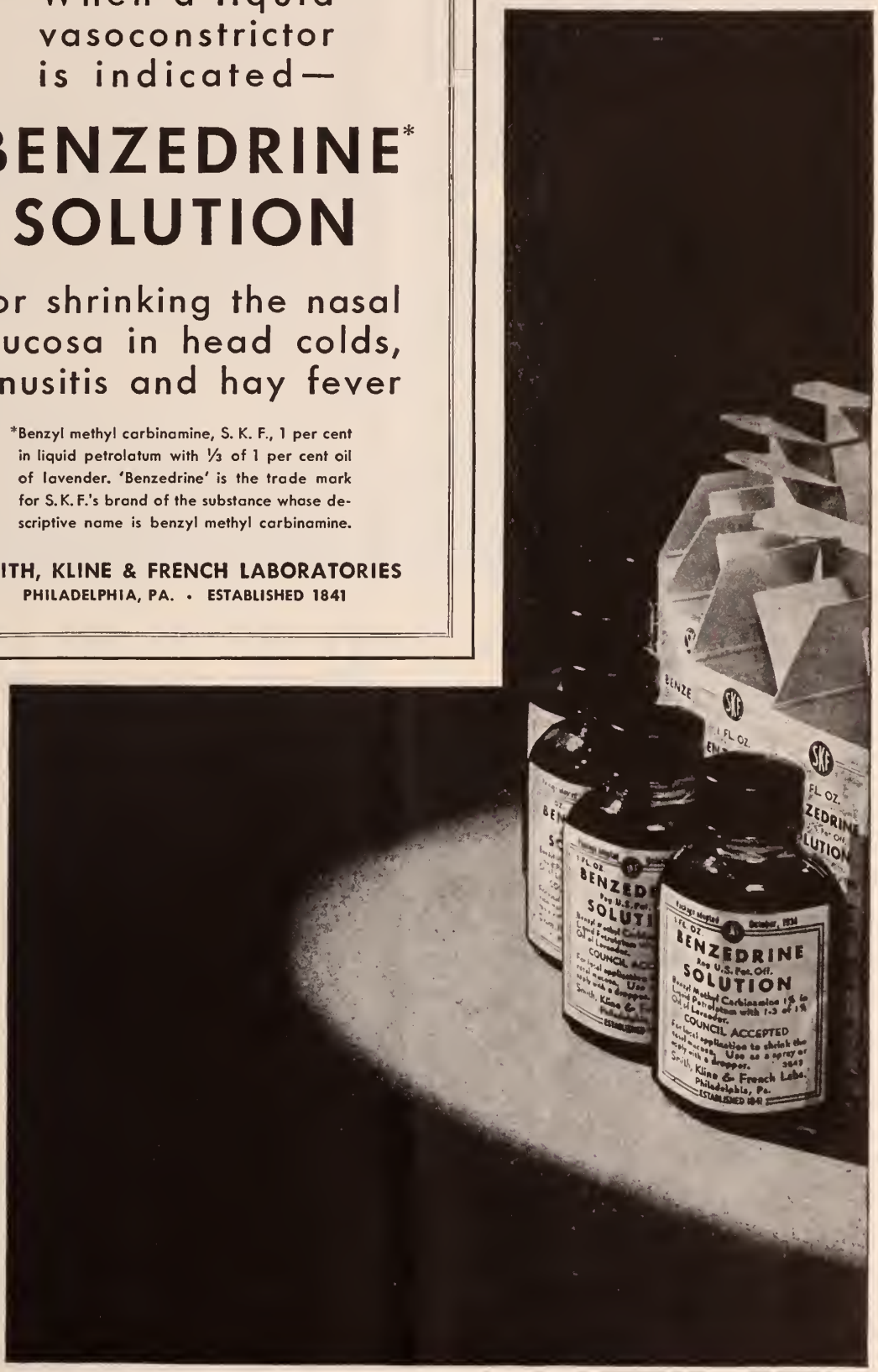
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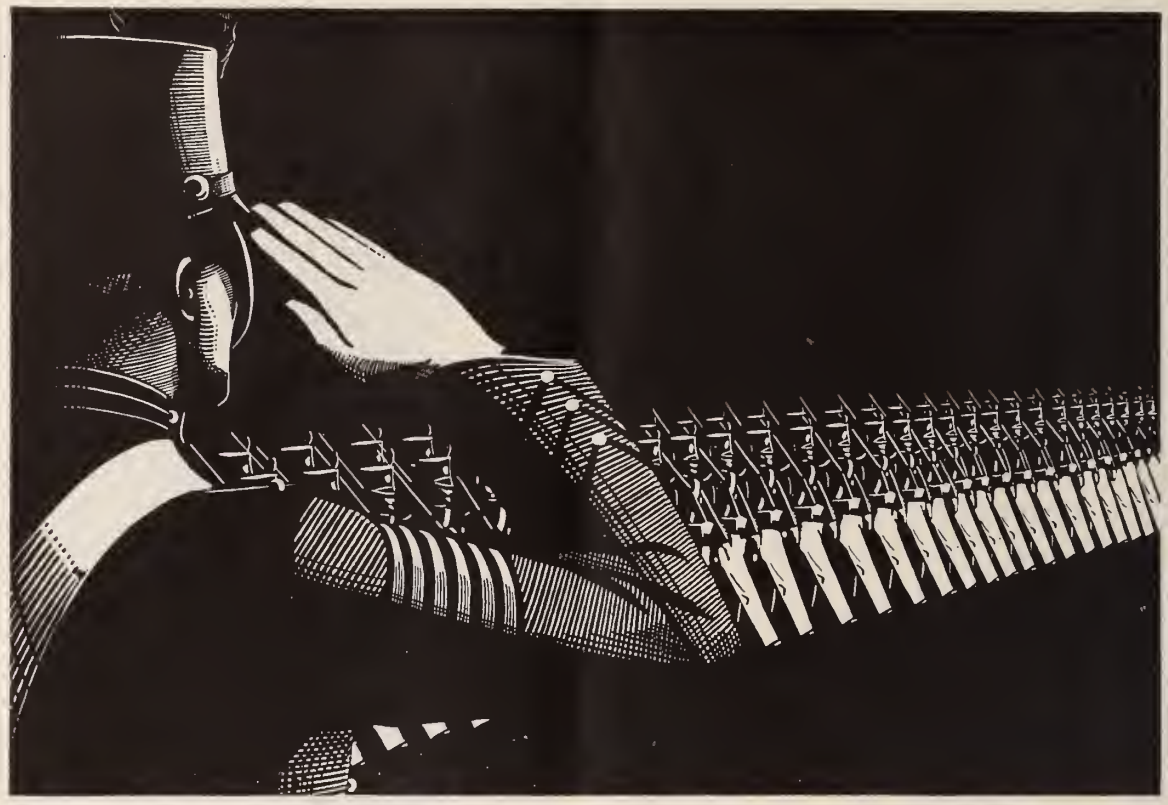
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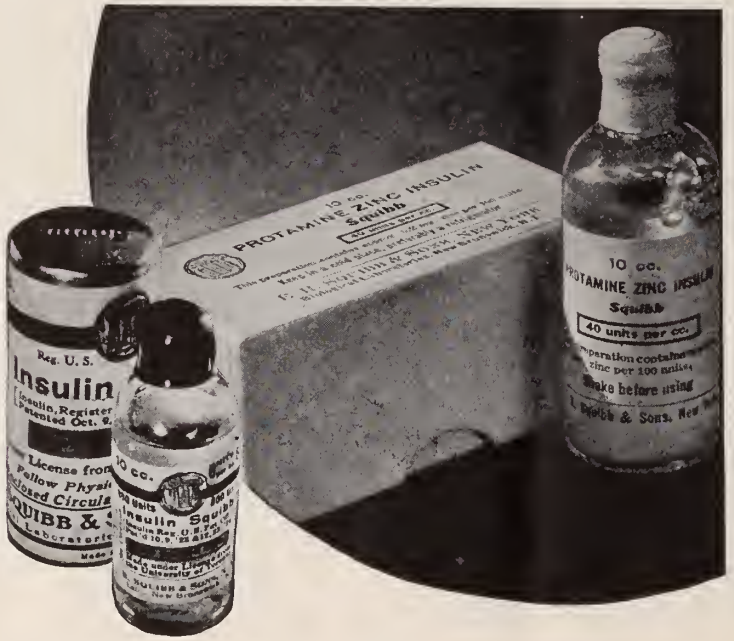
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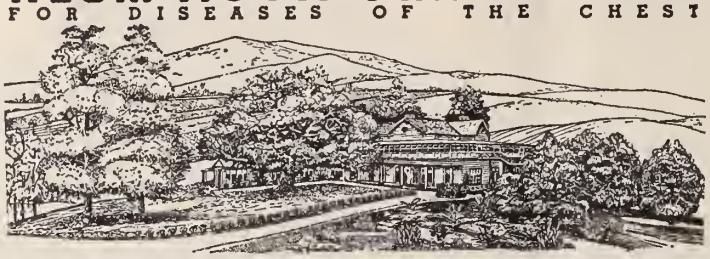
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(Continued from Page 40)

disturbances are seen. Mental derangements may simulate many forms of insanity. Dr. William McGurn lists 105 various disease conditions caused by this gas.

A series of acute poisonings was recently examined for late after-results. These cases were selected poisonings in which the victims had been unconscious for at least one-half hour and were examined from several months to over a year and one-half after the mishap. After-effects were taken only when proved to be definite results of the exposure and were found to be as follows: Extreme nervousness (in more than 50 per cent of the cases), twitching of the muscles, tremor of the fingers, insomnia, and emotional disturbances (mental retardation, rage, etc.). One patient has developed a marked, progressive dimness of vision. He had been gassed to unconsciousness on two occasions and lightly gassed in a third mishap. Several specialists who examined him found no organic cause for this loss of vision.

Other after-effects, fortunately rare, are complete deafness, blindness, loss of speech, paralysis, and gangrene.

Chronic carbon monoxid poisoning is produced by continual exposure to small amounts of the gas. Unfortunately we have no way of knowing what proportion of the population is continually complaining of minor illnesses really representing victims of this insidious condition. Proved cases of chronic poisoning exhibit symptoms which may occur in innumerable diseases. Some of these symptoms are frequent or continuous headaches, dizziness, hot flushes, palpitation of the heart, anemia, generalized weakness, and impaired mental functions. Fortunately, these symptoms generally disappear promptly when exposure to the gas ceases.

Here as in all problems in the treatment of diseases the best is prevention, of which we shall speak later.

For the immediate treatment of the acutely poisoned victim we should always remember, first, to remove him from the gas-filled atmosphere, and, second, artificial respiration by the well-known prone pressure method until respiration is going well. Be sure to call for help from the closest police station, fire department, physician, or hospital. Many of these are equipped with an inhalator containing a mixture of oxygen and carbon dioxid which can be promptly applied to the victim by the use of a face mask which accompanies the inhalator. They bring blankets, also, to keep the victim warm.

Again we say that prevention is the best treatment and ring the bells of warning that have so often been rung before, namely:

"Watch carefully in your home: (1) gas stove in the bedroom; (2) gas range used for heating a room; (3) water heater in the bathroom; (4) loose gas-cocks and pipe connections; (5) unflued gas fire in any room; (6) loose stove and furnace connections; and (7) do not pour water on hot coals.

"For your automobile: (1) do not start it in a closed garage; (2) do not work on it in a closed garage with the motor running (even five or ten minutes may be fatal); (3) do not sleep or park in it if the motor is running; (4) keep the motor tuned up in cold weather and the exhaust system tight."

Remember, too, that so long as ignorance and carelessness go hand in hand, carbon monoxid will continue to collect its appalling number of victims. — *Ohio Health News.*

What Every Woman Doesn't Know—How to Give Cod-Liver Oil.—Some authorities recommend that cod-liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will

(Continued on Page 48)



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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
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(Continued from Page 46)

place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

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If we are to make any progress in highway safety, we can no longer permit any and everyone who may so wish to take a car on the road.

The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.



A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Excercise . . . helpeth to restore the crooked Bones. . . ."

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SWADDLING was practised down through the centuries, from Biblical times to Glisson's day, in the vain hope that it would prevent the deformities of rickets. Even in sunny Italy swaddling was a prevailing custom, recommended by that early pediatrician, Soranus of Ephesus, who discoursed on "Why the Majority of Roman Children are Distorted."

"This is observed to happen more in the neighborhood of Rome than in other places," he wrote. "If no one oversees the infant's movements, his limbs do in the generality of cases become twisted. . . . Hence, when he first begins to sit he must be propped by swathings of bandages. . . ." Hundreds of years later swaddling was still prevalent in Italy, as attested by the sculptures of the della Robbias and their contemporaries. For infants who were strong Glisson suggested placing "Leaden Shooes" on their feet and suspending them with swaddling bands in mid-air.

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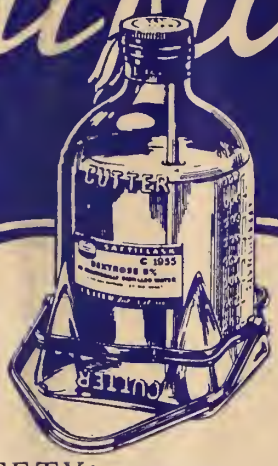
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Communications for the Public Relations Department should be addressed to the Director, Frederick C. Warnshuis, M. D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Orville Meland (Sec'y for Southern Section)	Los Angeles	1938
A. Herman Zeiler	Los Angeles	1938
Gertrude Moore	Oakland	1938
Harold Brunn	San Francisco	1939
Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
Charles A. Dukes (Chairman)	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940

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President, Clarence A. DePuy, 230 Grand Avenue, Oakland.

Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society

President, Raymond Kilduff, 322½ Meyers Street, Oroville.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Selby H. Marks, Grabstein Bldg., Pittsburg.

Secretary, Thomas J. Dozier, 202 G Street, Antioch.

Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society

President, Henry A. Randel, Box 2308, Fresno.

Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

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President, Francis M. Stump, Crescent City.

Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

President, Henry B. Graeser, 115 E. Fifth Street, Holtville.

Secretary, Merritt C. Canfield, 204 Professional Building, El Centro.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

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Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society

President, P. K. Edmunds, Corcoran.

Secretary, William A. Johnstone, Hanford.

Meeting, *Second Monday, 8 p.m., Legion Hall, Hanford.*

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President, C. I. Burnett, Susanville.

Secretary, Fred J. Davis, Jr., Westwood.

Meeting, *On Call.*

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1925 Wilshire Boulevard, Los Angeles

President, George H. Kress, 945 Roosevelt Bldg., 727 W. 7th St., Los Angeles.

Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, W. Scott Polland, Albert Building, San Rafael.

Secretary, Carl W. Clark, 510 B Street, San Rafael.

Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society

President, Thomas P. Hill, Lakeport.

Secretary, Charles A. Craig, Lakeport.

Meeting, *On Call.*

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President, E. M. Soderstrom, Merced.

Secretary, Fred O. Lien, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

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President, Curtis B. Gorham, 215 Franklin Street, Monterey.

Secretary, Harold R. Lusignan, 215 Franklin Strcet, Monterey.

Meeting, *First Thursday.*

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President, Fred Heegler, Migliavacca Building, Napa.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

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Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

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Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

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Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

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President, Dave Dozier, California State Life Building, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

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Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

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Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

President, Bryant R. Simpson, 1205 Medico-Dental Building, San Diego.

Secretary, W. H. Newman, Medico-Dental Building, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco

President, William C. Voorsanger, 490 Post St., San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, A. C. Boehmer, Box 306, Lodi.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, Frederick R. Mugler, 1170 Marsh Street, San Luis Obispo.

Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

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Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

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Secretary, J. Jerome Rupp, 16 E. Junipero Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, E. O. G. Schmitt, 608 Medico Dental Bldg., San Jose.

Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

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Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

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Meeting, *Second Monday.*

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Meeting, *Second Sunday.*

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Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

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* Deceased.

OPERATIVE GYNECOLOGY

By

H. S. CROSSEN, M.D., F.A.C.S.,

Professor of Clinical Gynecology, Washington University School of Medicine; and

R. J. CROSSEN, M.D.,

Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine.

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XX—Technic of Abdominal Operations	27 pages
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Las Encinas, Pasadena, California

LIVERMORE SANITARIUM
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Livermore, California

OAKS SANITARIUM
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Recent Statement by the Judges of the Mead Johnson Vitamin A Award.—"The Vitamin A Award offered by Mead Johnson & Company was supposed to be made on the basis of papers published or accepted for publication by December 31, 1936. The judges of this award, meeting in New York, June 4, 1937, feel that its presentation at this time is not warranted, since no clinical investigation on vitamin A has yet been published which completely answers any of the objectives of the original proposal. The judges, therefore, agreed to defer further consideration of the granting of this award until December 31, 1939. This action was taken because of the existence of pronounced differences of opinion among investigators as to the reliability of any method yet proposed for determining the actual vitamin A requirements."

Comment by Mead Johnson & Company: In view of this action by the judges of the Mead Johnson Vitamin A Award, and as an earnest of our good faith in the matter, we have segregated from our corporate funds on deposit with the Continental Illinois National Bank & Trust Company of Chicago the sum of $15,000. This cash deposit has been placed in escrow and will be paid promptly when the board of judges decides on the recipient of the Main or Clinical Award. The Laboratory Award of $5,000 was made on April 10, 1935.

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The individual is not unlike the race. At first, as a wanderer, he tries ways and places; then, settling somewhere, he devotes himself to work. His best years are spent in making and doing. While long and faithful toil pays a man, yet upon occasion an "old hand" may wisely turn to something new. We form habits and so save energy; we do well, however, to stop short of being slaves of a habit. The world undergoes ceaseless change. We should, therefore, be on the alert to find out the meaning of what is happening around us and thereby assess the value of what we are doing. Thus, by continual learning we cope with change. Life for us moves swiftly; within recent decades it has become highly complex. To keep up with the times we must keep up our knowledge. Many watch the world rush by and take no pains to find out what the hubbub is about. Political ideals, the social order, methods of production and distribution, systems of finance, and many other things are undergoing change. Only those who study are not left behind by the onrolling globe.—Leon J. Richardson.

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Macleod's Physiology in Modern Medicine. Edited by Philip Bard, Professor of Physiology, Johns Hopkins University School of Medicine, with the collaboration of Henry C. Bazett, Professor of Physiology, University of Pennsylvania; George R. Cowgill, Associate Professor of Physiological Chemistry, Yale University School of Medicine; Harry Eagle, Passed Assistant Surgeon, United States Public Health Service and Lecturer in Medicine, Johns Hopkins University School of Medicine; Chalmers L. Gemmill, Associate in Physiology, Johns Hopkins University School of Medicine; Magnus I. Gregersen, Professor of Physiology, College of Physicians and Surgeons, Columbia University, Formerly Professor of Physiology, University of Maryland School of Medicine; Roy G. Hoskins, Director of Research, Memorial Foundation for Neuro-endocrine Research, Research Associate in Physiology, Harvard Medical School; J. M. D. Olmsted, Professor of Physiology, University of California; and Carl F. Schmidt, Professor of Pharmacology, University of Pennsylvania. Eighth Edition. Cloth. Pp. 1051, with illustrations. Price, $8.50. St. Louis: The C. V. Mosby Company, 1938.

Essentials of Prescription Writing. By Cary Eggleston, M. D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City. Sixth Edition, Revised. Cloth. Pp. 155. Price, $1.50 net. Philadelphia: W. B. Saunders Company, 1938.

Surgical Diseases of the Mouth and Jaw. By Earl Calvin Padgett, B. S., M. D., F. A. C. S., Associate Professor of Clinical Surgery, University of Kansas School of Medicine, Kansas City, Kansas; Associate Professor of Oral Surgery, Kansas City Western Dental College, Kansas City, Missouri. Cloth. Pp. 807, with 334 illustrations. Price, $10 net. Philadelphia: W. B. Saunders Company, 1938.

Approved Laboratory Technic. Clinical Pathological, Bacteriological, Mycological, Parasitological, Serological, Biochemical, and Histological. By John A. Kolmer, M. D., Dr. P. H., Sc. D., LL. D., L. H. D., F. A. C. P., Professor of Medicine, Temple University; Director of the Research Institute of Cutaneous Medicine, Philadelphia; Formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania, and Fred Boerner, V. M. D., Assistant Professor of Bacteriology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Bacteriologist, Graduate Hospital, Philadelphia. Second Edition. Rewritten, revised, and reset. Cloth. Pp. 893, with 12 plates and 380 illustrations in the text. New York: D. Appleton-Century Company, 1938.

(Continued on Page 15)

A HANDBOOK OF
ACCEPTED REMEDIES
Symptoms and Treatment of Poisoning, Diagnostic Procedures and Miscellaneous Information
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*J. A. M. A., July 31, 1937. P. 330.
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*CORCORAN, New York State Journal of Medicine, Jan. 1, 1930

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BOOKS RECEIVED

(Continued from Page 13)

Short Years. The Life and Letters of John Bruce MacCallum, M. D., 1876-1906. By Archibald Malloch. Cloth. Pp. 343. Price, $3.50. Chicago: Normandie House, 1937.

Love and Happiness. Intimate Problems of the Modern Woman. By I. M. Hotep, M. D. With a Prefatory Note by Dr. Logan Clendening. Cloth. Pp. 235. Price, $2. New York: Alfred A. Knopf, 1938.

Fever Therapy. Abstracts and Discussions of Papers Presented at the First International Conference on Fever Therapy, College of Physicians and Surgeons, Columbia University, New York City, March 29, 30, 31, 1937. Edited by the Members of the American Committee: Dr. Walter M. Simpson, Dayton, Ohio, Chairman; Dr. William Bierman, New York City, Secretary; Dr. Charles M. Carpenter, Rochester, N. Y.; Dr. Charles A. Doan, Columbus, Ohio; Dr. Frank W. Hartman, Detroit, Michigan; Dr. Leland E. Hinsie, New York City; Dr. Frank H. Drusen, Rochester, Minnesota; Dr. Clarence A. Neymann, Chicago, Illinois; and Dr. Stafford L. Warren, Rochester, New York. Cloth. Pp. 486. Price, $5. New York: Paul B. Hoeber, Inc., 1937.

Josiah Macy, Jr., Foundation. A Review by the President of Activities for the Six Years Ended December 31, 1936, with Extracts from the Treasurer's Reports for the Years 1932-1936. Paper. Pp. 137. New York: 565 Park Avenue, 1937.

Proceedings of the Thirty-first Annual Convention of the Association of Life Insurance Presidents. Held in the Waldorf-Astoria, New York, N. Y., December 2-3, 1937. Paper. Pp. 254.

(Continued on Next Page)

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BOOK REVIEWS

(Continued from Preceding Page)

Macleod's Physiology in Modern Medicine. Edited by Philip Bard. Cloth. Pp. 1050. Eighth Edition. Price, $8.50. St. Louis, Missouri: C. V. Mosby Company.

Professor Bard, with the collaboration of eight capable men, is "carrying on," and providing the profession with this valued text brought up to date in this eighth edition. The greater part of the book has been rewritten. Each major division is under the editorial supervision of an acknowledged authority.

The text is a guide to the clinical application of physiology and biochemistry. This clinical feature enhances the text and extends its contents to the clinician, a commendable purpose. Laboratory findings are brought to the bedside.

Every physician does well to secure, study, and consult this text daily. He will be a better physician for having done so.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 152)

shall leave it untouched. Malignant growths are almost the only ones found in the esophagus; their removal belongs to general surgery.

In discussing the removal of foreign bodies, I suppose some mention should be made of the older and well-known methods. But I shall give very little time to this part of the subject, for I believe that those older methods are so blind and uncertain and dangerous that they should be discarded in practically every case where esophagoscopy is available. The number of men employing esophagoscopy is increasing rapidly, so that in the near future this means of relief will be available in nearly all parts of the country. And while time is very important in these cases, it will frequently mean less danger to the patient to take the time necessary to reach an esophagoscopist than to try to remove the foreign body by the old means.

(Continued on Page 19)

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2000 U. S. P. Units added
per tall can (13 fluid ounces)



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400 U. S. P. Units added
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- THE VITAMIN D ADDED PER TALL (13 FLUID OZ.) CAN REPRESENTS THE AMOUNT IN 1¼ TEASPOONS OF U.S.P. COD LIVER OIL (315 UNITS PER TEASPOON).
- SPECIAL MORNING MILK IS THE ONLY EVAPORATED MILK PRODUCED IN CALIFORNIA USING COD LIVER OIL CONCENTRATE AS ITS SOURCE OF VITAMIN D.
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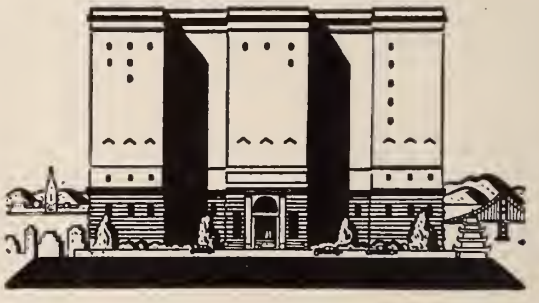
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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

From an article on "Gasserectomy," with Report of Three Cases, by J. Henry Barbat, M.D., San Francisco.—These cases are reported on account of the unpleasant complications encountered during operation. We are struck by the fact that this operation, when performed on the cadaver is very easy of accomplishment, but on the living body we are confronted with the one thing which makes intracranial surgery extremely difficult and at times fatal, and that is hemorrhage. . . .

From an article on "Tuberculosis Among Railroad Employees," by John C. King, M.D., Banning.—Tuberculosis is ubiquitous, therefore railroad employees suffer from it. The percentage of morbidity is probably less among them than among any other large mass of employees, except those in the army and navy. They are obliged to submit to physical examination prior to employment. Life insurance actuaries claim that examination discriminates in favor of the company for a period not to exceed five years. Likewise, the examination of our men protects the company for only a limited though uncertain time. . . .

From some Society Reports:

Alameda County.—The annual meeting of the Alameda County Medical Association was called to order by the president, W. A. Clark, at the Young Men's Christian Association Building, Tuesday evening, December 17, 1912, at 8:30 o'clock.

The election of officers, councilors, delegates and alternates resulted as follows:

President, Dr. M. L. Emerson; Vice-President, Dr. Dudley Smith; Secretary-Treasurer, Dr. Elmer E. Brinckerhoff; Councilors, Drs. N. H. Chamberlain, J. A. Ellis, W. H. Irwin, C. W. Page, Alvin Powell, G. G. Reinle; Delegates, Drs. Elmer E. Brinckerhoff, T. J. Clark, W. A.

(Continued on Next Page)

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†IRON	0.005 GRAM	*TRACE	0.005 GRAM
†VITAMIN D	134 U.S.P. UNITS	*SMALL AMOUNT; VARIABLE	134 U.S.P. UNITS
†CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
†PHOSPHORUS	0.16 "	0.17 "	0.33 "
PROTEIN	4.00 GRAMS	7.92 GRAMS	11.92 GRAMS
FAT	1.25 "	8.53 "	9.78 "
CARBOHYDRATES	21.50 "	10.97 "	32.47 "

★ *Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.*

† *Cocomalt, the protective food drink,* is fortified *with these amounts of Calcium, Phosphorus, Iron and Vitamin D.*

Thus, since each ounce-serving of Cocomalt has been *fortified* with .15 gram of Calcium, .16 gram of Phosphorus, an 8-oz. glass of milk with 1-oz. of Cocomalt provides .39 gram of Calcium, .33 gram of Phosphorus. And, helping insure that the system can utilize these food-minerals, each ounce of Cocomalt also contains 134 U.S.P. Units of Vitamin D, derived from natural oils and biologically tested for potency. The 5 milligrams of effective Iron in each ounce of Cocomalt are biologically tested for assimilation.

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Clark, David Hadden; and Alternates, Drs. L. P. Adams, C. G. Bull, C. E. Curdts, A. Galbraith, A. F. Gillihan, J. L. Lohse, J. L. Milton, and R. T. Sutherland.

* * *

Butte County. — The Butte County Medical Society held its monthly meeting at the offices of Dr. Gatchell at 8:00 p.m., January 14.

Doctor Gougout read a paper on "Bright's Disease."

The following officers were elected for 1913; President, P. L. Hamilton; Vice-President, T. B. Reardon of Oroville, and Secretary-Treasurer, Ella F. Gatchell.

* * *

Annual Meeting of the Los Angeles County Medical Association.—The annual meeting of the Los Angeles County Medical Association was held on Thursday evening, December 19, 1912.

The officers and committees for the coming year are as follows: *Officers:* William M. Lewis, M.D., Auditorium Building, President; A. S. Lobingier, M.D., Story Building, Vice-President; George H. Kress, M.D., 245 Bradbury Building, Secretary-Treasurer and Editor of the *Bulletin.*

Part II. General Report (Report of Secretary).—The year just closed has been characterized by steady, forward progress, the most notable items be-

(Continued on Page 22)

It Can Happen Here



Example of severe rickets in a sunny clime. Courtesy of E. H. Christopherson, M.D., San Diego, and of "California and Western Medicine."

LEST WE FORGET—we who are of the vitamin D era—severe rickets is not yet eradicated, and moderate and mild rickets are still prevalent. Here is a white child, supposedly well fed, if judged by weight alone, a farm child apparently living out of doors a good deal. This boy was reared in a state having a latitude between 37° and 42°, where the average amount of fall and winter sunshine is *equal to that in the major portion of the United States*. And yet such stigmata of rickets as *genu varum* and the quadratic head are plain evidence that rickets does occur under these conditions.

How much more likely, then, that rickets will develop among city-bred children who live under a smokepall for a large part of each year. True, vitamin D is more or less routinely prescribed nowadays for infants. But is the antiricketic routinely administered in the home? Does the child refuse it? Is it given in some unstandardized form, purchased from a false sense of economy because the physician did not specify the kind?

A uniformly potent source of vitamin D such as Oleum Percomorphum, administered regularly in proper dosage, can do more than protect against the gross visible deformities of rickets. It may prevent hidden but nonetheless serious malformations of the chest and the pelvis and will aid in promoting good dentition. Because the dosage is measured in *drops*, Oleum Percomorphum is well taken and well tolerated by infants and growing children. Rigid bioassays assure a uniform potency—100 times the vitamins A and D content of cod liver oil*. Oleum Percomorphum, moreover, is a natural product in which the vitamins are in the same ratio as in cod liver oil*.

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Oleum Percomorphum offers not less than 60,000 vitamin A units and 8,500 vitamin D units (U. S.P.) per gram. Supplied in 10 and 50 c. c. brown bottles, also in 10-drop soluble gelatin capsules, each offering not less than 13,300 vitamin A units and 1,850 vitamin D units, in boxes of 25 and 100.

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

ing the continued increase in membership, and the inauguration of the medical office building proposition.

Membership.—The total number of members for whom we paid assessments to our State Society was six hundred.

It will not be out of place to again give here, as a matter of record, the total membership of the Los Angeles County Medical Association during the last several years.

In year 1905, total membership was 315 members.

In year 1906, total membership was 359 members, gain 44 members.

In year 1907, total membership was 393 members, gain 34 members.

In year 1908, total membership was 398 members, gain 5 members.

In year 1909, total membership was 402 members, gain 4 members.

In year 1910, total membership was 457 members, gain 4 members.

In year 1911, total membership was 561 members, gain 104 members.

In year 1912, total membership is 600 members, gain 39 members.

It is evident from the above figures that the Association is continuing its steady progress as regards increase of its membership.

Report of Board on Permanent Quarters.—Mr. President and Members of the Los Angeles County Medical Association:

The first annual report of this Board was printed in the *Bulletin* of January 5, 1912, and showed a balance on hand of $9,677.61.

Of the above amount $819.72 represented the savings of our Society up to the time of the Los Angeles meeting of the American Medical Association in 1911, and the balance of $8,857.89 was what was left of the entertainment fund when all the debts of the American Medical Association meeting had been paid.

The Board of Permanent Quarters, after careful consideration and with the consent of the Board of Councilors, purchased in the name of the Los Angeles County Medical Association, an option on the splendidly located lot at the southeast corner of Sixth and Olive streets owned by Mr. H. W. Spiers.

The Board of Permanent Quarters, therefore, makes an appeal to each and every member of the Association to lend a hand in what can be made and what we hope will be, the biggest and most successful enterprise our Society has ever undertaken.

Respectfully submitted,

H. Bert Ellis, *Chairman,*
Baard of Permanent Quarters.

✦ ✦ ✦

Annual Meeting, San Francisco County Medical Saciety, December 10, 1912.—Presidential address by Dudley Tait:

Fellow Members:

I wish, first of all, to thank you for the honor, which I esteem so highly, of having been permitted to preside at your meetings and to address you tonight.

During the past year the policy of the San Francisco County Medical Society, as outlined by your directors, your inspiring and indefatigable secretary, and serious-minded committees, had but one single aim: the strengthening of the Society as a factor in the profession, as well as from the viewpoint of the public. . . .

Report of Secretary-Treasurer.—

Mr. President and Members of the San Francisco County Medical Society:

As Secretary I beg leave to submit the following report

(Continued on Page 24)

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It's Individualized Care

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Well tolerated
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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

for the year 1912, that is from December 10, 1911, to December 10, 1912, inclusive:

Number of members in Society December 10, 1911	548
New members admitted	36
Resigned	4
Transferred to other county societies	2
Died	5
Expelled	1
Dropped for non-payment of dues	10
On leave of absence	6
Number of members in Society December 10, 1912	556

BOARD OF MEDICAL EXAMINERS

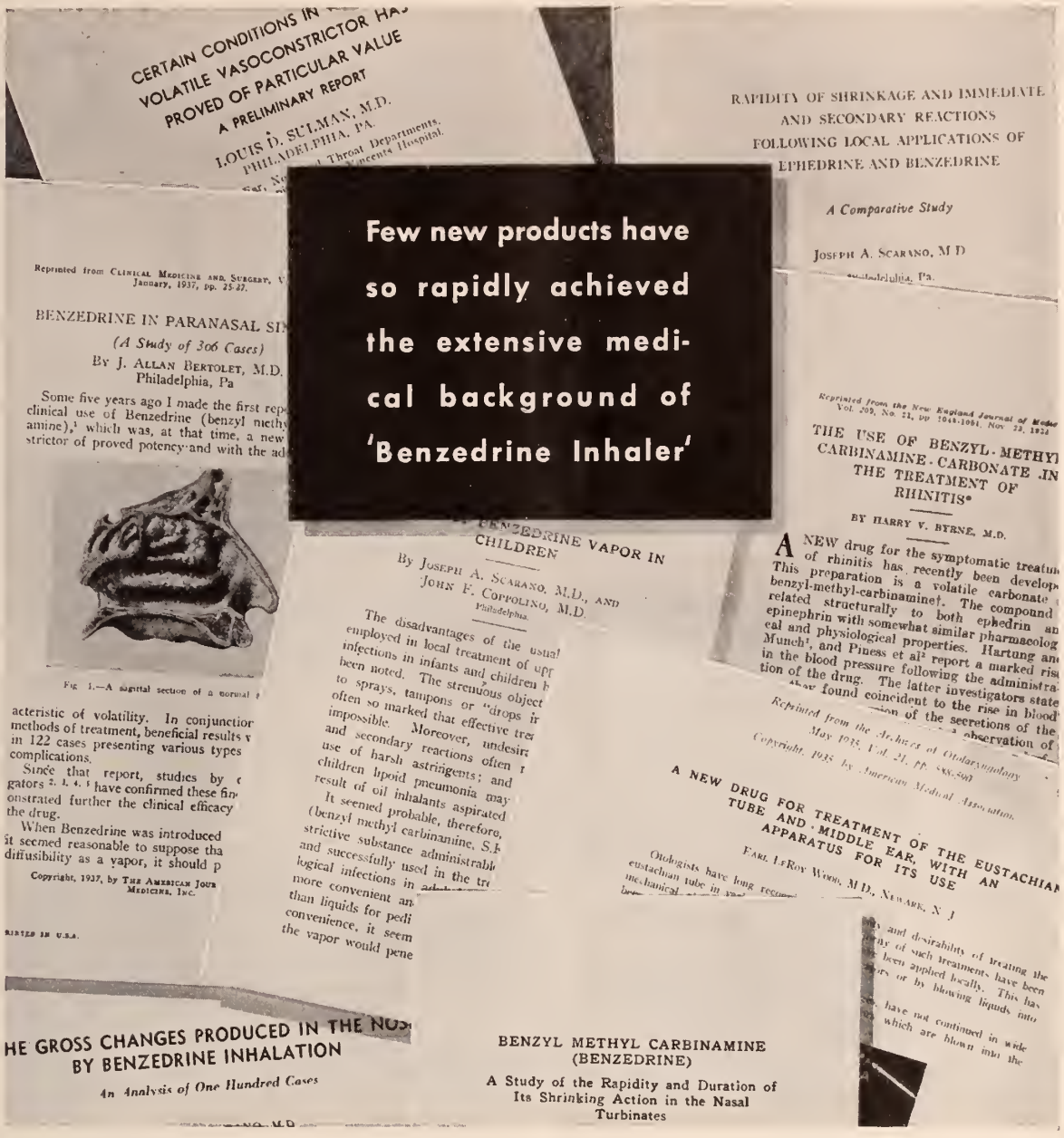
(Continued from Text Page 152)

"'I cannot forget the vivid picture of you breaking a man's arm. There is enough misery in this world without intentionally causing suffering.' It was Superior Judge Frank M. Smith speaking today as a jurist who has seen much of the cruelties of life. It was his comment as he sentenced Joe Bone, confessed 'brains' and 'bone crusher' in the half-million-dollar fifty-person 'fake accident ring,' to a term of one to ten years in San Quentin prison. 'There is no place in the world for a man like you except behind prison bars,' Judge Smith added. On a plea of guilty, Etta Hargett, twenty-seven, whose case launched the investigations which uncovered the fake accident ring, was given five years' probation, sixty days in jail, and a $250 fine as restitution for her portion of the $600 that was assertedly paid on a fake street-car accident claim. When he spoke of the 'vivid picture,' he was thinking of testimony in a case several weeks ago in which Peter De Nooy, prosecution witness, declared: 'I put my left arm across the blocks. Then Mr. Bone swung the club down on me, cracking my forearm. It felt terrible.' The gigantic fake accident ring assertedly victimized insurance companies by inducing persons to represent falsely that they had received injuries in automobile and street-car accidents. Nearly a half-million dollars was assertedly taken from insurance companies in such operations. Bone was sentenced only on a basis of allegations in connection with a 'fake' accident involving Mr. and Mrs. Bert Howard. Mrs. Howard is serving a jail sentence. Her husband was never apprehended. Bone may face other possible consecutive sentences. George O. Dorris, former street-car company adjuster and asserted co-leader with Bone in the plot, is facing sentence in another court. . . . Case of Louis Feinstein, attorney, under indictment in connection with asserted 'ambulance chasing,' was continued to January 24." (Los Angeles *Herald and Express,* December 16, 1937.)

"Dr. Louis Kameny, Oakland physician, and Emile Grossman, East Bay attorney, convicted on six counts of conspiracy to commit grand theft, will have another week's grace before sentence is pronounced. Tuesday Alameda County Superior Judge Lincoln S. Church postponed sentence until January 11 on the request of the county probation officer who requested the continuation to complete his investigation of the pair, who asked probation. They were engaged in an asserted 'insurance racket,' allegedly attempted to post-date an accident to defraud an insurance company." (San Francisco *Examiner,* January 6, 1938.)

"Raiding a palatial, twenty-room dwelling at 694 South Hobart Boulevard, police late yesterday arrested Dr. Paul C. Fowler (licensed chiropractor) on charges growing out of an alleged illegal operation. A patient of Doctor Fowler, Mrs. Lucille Winter, according to investigators, is near death in General Hospital as a result of the alleged operation. Two women, one being treated and another awaiting treatment for unknown ailments, were in the luxuriously

(Continued on Page 26)



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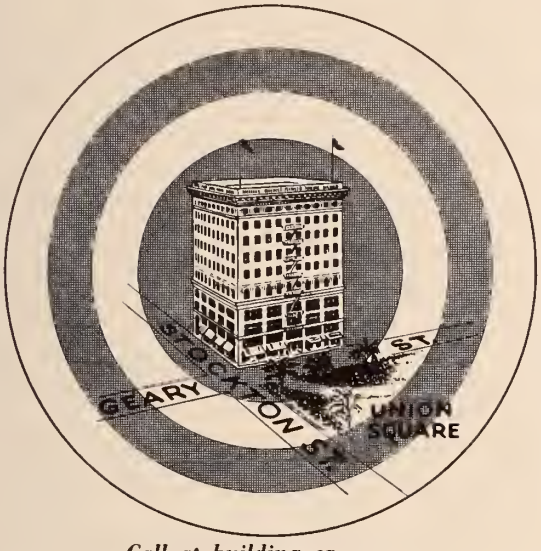
(Continued from Page 24)

furnished office in the well-equipped Wilshire district residence when the officers and an agent of the State Board of Medical Examiners entered. Scores of costly surgical instruments, a quantity of narcotics, and hypodermic paraphernalia were seized in the raid, led by W. N. Anderson, investigator for the State Medical Board, and Detective Lieutenants R. B. McCreadie and Frank R. Harper. They acted on a warrant charging Doctor Fowler with medical practice allegedly exceeding the scope of his chiropractor's license. . . ." (Los Angeles *Examiner*, January 6, 1938.) A photograph now in possession of the Board of Medical Examiners shows the above-mentioned array of instruments, which include uterine dilators, forceps, vaginal speculums, uterine curettes, irrigators, a large number of glass syringes of various sizes, also a sign reading "Dr. Paul C. Fowler, Diagnosis, Psychiatry—Dr. A. B. Carmichael, Physician and Surgeon." (Under jurisdiction of the Board of Osteopathic Examiners.) Said photograph also shows an open book wherein the title appears "Abortions" by Doctor Taussig. Investigator Walter N. Anderson, in his report of January 7, 1938, states that Chiropractor Fowler "was committed to jail in default of $1,000 bail. . . . At the time of the raid, two vials of morphin sulphate . . . were found in his possession." Said report also relates that "Fowler admitted . . . that prior to the disruption of the Rankin-Watts abortion ring, he referred abortion cases to them, and that many of the instruments (seen) in the picture (above referred to) Fowler stated were purchased from the well-known Doctor Watts. It is also interesting to note that Mrs. G. E. Watts's name appears in the daybook of Chiropractor Fowler. The name of Dr. St. John also appears in the same book. . . ." The records of the Board of Chiropractic Examiners show that Paul C. Fowler, a graduate of the Wentworth Chiropractic School, Duluth, Minnesota, June 1, 1920, holds chiropractic license No. 3033, issued March 8, 1930.

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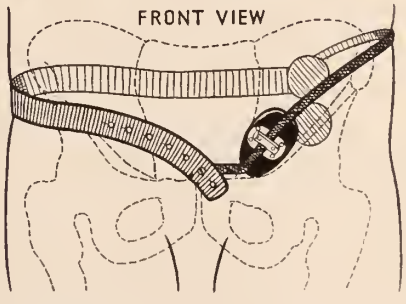
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"A brief, consuming some 335 pages, and aimed at reversal of the conviction of Dr. Claude C. Long for the abortion death of a woman patient, was filed in the State Supreme Court yesterday. Principal charges in the lengthy document were that the physician was convicted on insufficient evidence. . . . Doctor Long was convicted of manslaughter last August by the same jury that acquitted his wife, Isabelle, and his office nurse, Mrs. Ann Fisher." (San Francisco *Chronicle*, January 1, 1938.)

"Tessie Sitton Noel, forty-nine, a nurse, was sentenced by Superior Judge Walter Desmond yesterday to two to five years in the Women's Prison at Tehachapi, the term prescribed by law, with the recommendation to the Prison Board that Mrs. Noel be kept there for the maximum sentence. The sentence was pronounced after the court had denied a plea for probation on one count of having performed an illegal operation. Two similar counts had been dismissed on motion of the District Attorney's office. 'The report of the probation officer in this case reveals a trail of murder,' said the court. 'The report indicates the guilt of the defendant on all three counts. I will say very definitely that if I had known there was a record of crime and murder, I would never have permitted the plea to one count. Therefore, of course, I am going to deny the application for probation and sentence the defendant to the penitentiary. . . .' Mrs. Noel, who claims to have been an ordained minister for twenty years as well as a nurse, and who on the occasion of her preliminary hearing threw the courtroom into an uproar with an outburst of religious shoutings, maintained her innocence to the last in spite of her previous plea of guilty. Mrs. Noel was arrested in September after an investigation by Detectives W. J. Sibley and R. H. Manchester had resulted in discovery of the body of a perfectly formed boy baby preserved in a jar of alcohol in a trunk which had been placed in storage by Mrs. Noel. The body of a second baby was found the next day in a suitcase found in a closet of an East Tenth Street

(Continued on Next Page)

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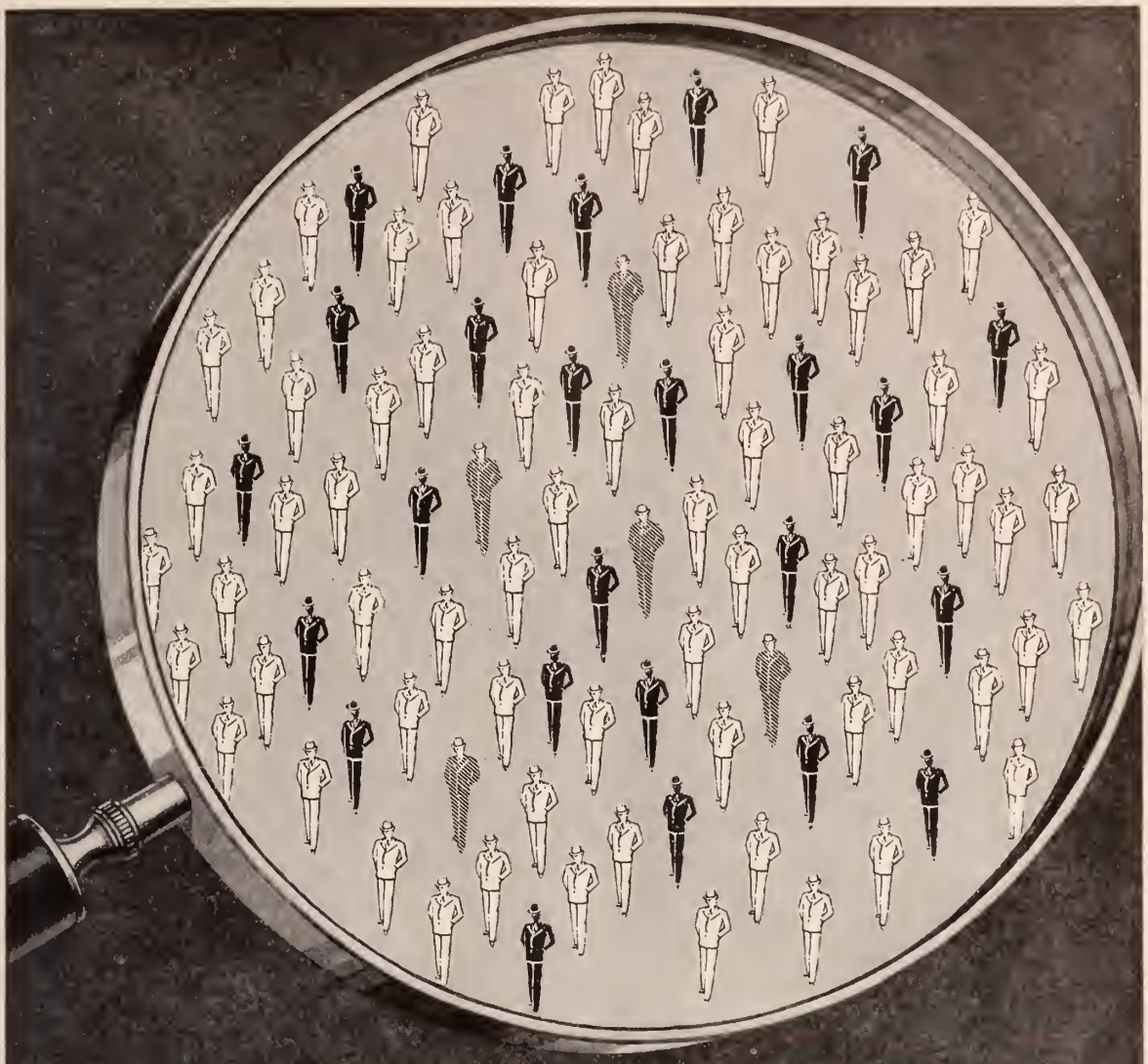
(Continued from Preceding Page)

boarding house which had been formerly operated by Mrs. Noel. An operation victim told of the burial of another baby in the yard on Tenth Street, but the body never was found." (Long Beach *Sun*, December 30, 1937.)

"Just as they were about to go to trial, charged with performing an illegal operation on an Oakland woman, Mrs. Annabelle McLellan, widow of Dr. Gordon McLellan, Mrs. Lucille Bouton, nurse, pleaded guilty. Their admission of guilt was made in the courtroom of Judge E. J. Tyrrell just after a jury had been chosen for the trial and evidence was to be introduced. . . . Judge Tyrrell set next Monday as the day of sentence. Both women may be sentenced, under the law, to a maximum of three years for conspiracy to commit an illegal operation." (San Francisco *Chronicle*, January 6, 1938.)

"Signing 'Dr.' before his name while he was on probation for two counts of violation of the Medical Act resulted in J. David Dunlop being sentenced to six months in the county jail today by Justice of the Peace William E. Fox for violation of probation. Dunlop last appeared in the local justice court in May, 1936. At that time he was found guilty of practicing medicine without a license and placed on probation. He was instructed to leave the State and refrain from practicing medicine. Henri V. Nier, Hollywood physical director, was the complaining witness. A letter written to him by the defendant was presented as evidence. He told the court that when he checked with the State Medical Board to ascertain if 'Dr.' Dunlop was

(Continued on Page 30)



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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

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* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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(Continued from Page 28)

licensed to practice, he was informed the defendant was a fake. Mr. Dunlop told the court the reason he signed his letter Dr. J. D. Dunlop was because everyone called him 'Doc.'" (Pasadena *Star-News*, December 20, 1937.)

"Defended by Attorney Lloyd C. Griffith in Judge Frank Smith's court Thursday, Dr. Ralph W. Bledsoe was freed of charges of 'soliciting the commission of grand theft' growing out of a secret grand jury investigation of the fake accident, insurance fraud case in which scores of prominent colored physicians have been indicted and tried during the last two months. . . . As to the fake accident ring, Doctor Bledsoe said he had no connection with it or any of its fixers or cases. An ex-convict, Leon Kent, was chief witness against the physician. . . ." (Los Angeles *Califarnia Eagle*, December 30, 1937.)

"Dr. Mahlon C. Cooley, physician, pleaded guilty Monday in Superior Judge Frank Smith's court to a charge of soliciting a woman to commit a crime in the fake accident case of a group of white insurance swindlers. . . ." (Los Angeles *Califarnia Eagle*, December 16, 1937.)

"W. Jean Bolle, jailed in Detroit last week for impersonating a federal officer and posing as a physician and surgeon, will be returned to San Rafael for trial on charges of forgery and grand theft, it was indicated yesterday. The dapper Bolle, once divisional manager for a nationally known patent medicine company, was named in a complaint signed by his bride of five months. . . . Police records revealed that Bolle has posed as Dr. W. Gene Jourde-Bolle,

(Continued on Page 34)



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CALIFORNIA AND WESTERN MEDICINE

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EDITOR GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

CALIFORNIA COUNTY HOSPITAL BUREAUCRACY! WHICH WAY LEADING?—STATE MEDICINE, THROUGH A BACK-DOOR ENTRANCE?

Kern County Hospital Controversy Revived. Several years ago, in connection with the administration of Kern County's hospital, some important issues arose, when a group of citizens contended that the Board of Supervisors was using county funds to provide hospital care, not only for the indigent sick, but also, and illegally, for persons themselves well able to pay for hospitalization in private institutions, or having relatives legally liable for their support. The case came to trial in the Superior Court of Kern County, where Judge K. Van Zante handed down, on December 4, 1933, his opinion. An appeal from Judge Van Zante's decision was taken by a group of taxpayers of that county (Civil case No. 1761), and on January 30, 1936, the Fourth Appellate District Court of California rendered its ruling on the prior decision of the lower Superior Court.

For careful perusal by members of the California Medical Association, this opinion of the Appellate Court, as given by Justices Marks, Barnard and Jennings, is printed in full, under the caption Exhibit D, on page 106, in this issue; because that decision, since it was handed down two years ago, has been set forth in several California counties as an excuse and a right, presumably legal, to inaugurate what are little less than radical departures from former procedures having to do with the admission of patients into county hospitals, these innovations amounting practically to a form of state medicine, or perhaps something worse.

* * *

The Los Angeles County Hospital as a Major Offender.—Our comments, in this issue of the OFFICIAL JOURNAL, on what is taking place in some of our county hospitals, will be largely confined to some startling and little less than outrageous procedures which have been inaugurated in the Los Angeles County General Hospital during the last six months, or since about July 1, 1937, the beginning of the present county fiscal year.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

The Los Angeles County General Hospital: Its Organization.—First, a few words about the Los Angeles County General Hospital, a public institution which the County of Los Angeles, as a constituent unit of the State of California, in accordance with provisions in the constitution of the State designed to conserve the health and lives of indigent citizens, maintains under supervision of a board of five supervisors elected from the five geographical supervisorial districts.

The Los Angeles County *General* Hospital, under the general jurisdiction of the County's Department of Charities, has two divisions: the "Los Angeles County Hospital," a unit with an attending staff of 508 physicians and surgeons licensed under the Medical Practice Act of California, and the "Los Angeles County Osteopathic Hospital," staffed by licentiates of the California Board of Osteopathic Examiners. The two divisions are quite independent, one from the other, but what is stated below concerning bills rendered to patients applies not only equally to the two divisions, but also to the large county tuberculosis hospital known as Olive View Sanatorium, an institution having about 1,000 in-patients; the county also providing hospitalization for about 1,000 additional patients housed in some twenty tuberculosis rest homes, and likewise giving tuberculosis relief for an additional 2,000 patients who are hospitalized in their own homes.

What the capital investment of the Los Angeles County General Hospital, located on Mission Road and State Street, as represented by its acreage and buildings, amounts to, we do not know, but it may be of interest to note that the new acute unit of the Los Angeles County Hospital, opened several years ago, was erected and equipped at a cost of some seventeen millions of dollars. These figures may have a bearing on some of the new hospitalization charges made by the Department of Charities and County Hospital authorities, brought into being, it has been stated, because of interpretations of the Appellate Court opinion in the Kern County Hospital case.*

* * *

Los Angeles County Hospital Admits More Than 50,000 Patients Yearly.—In the Los Angeles County Hospital (medical division of the Los Angeles County General Hospital), during the fiscal year July 1, 1935-July 1, 1936, a total of 57,100 patients were enrolled as in-patients; and during the next fiscal year, 1936-1937, a total of 56,774 in-patients received care. The average number of patient days was 14.6 in 1935-1936, and 14.7 in 1936-1937.

At this moment, we do not have at hand the total number of hospitalized patients admitted there in previous years, nor are the figures available for patients registered in the tuberculosis division (Olive View and adjuncts), or those on the infirmary rolls of Rancho Los Amigos (the County Farm). For our purpose, in order to point out the deplorable system recently instituted, the massive total of 56,774 in-patients for the last fiscal year will suffice, since an approximately similar registration may be expected to obtain for the current fiscal year.

* * *

What Is Wrong in the New Admission System of the Los Angeles County Hospital?—Now, what are the particular procedures to which objection and complaint are made, and why?

1. Since July 1, 1937, every patient (whether socially serviced and registered, and acknowledged as a 100 per cent "indigent," or a "medically indigent person" (part indigent?), or a "non-indigent" in law (this last citizen, presumably a person who himself, or, through legally-liable relatives, possesses means sufficient for his support, in health and in illness), has been receiving a statement from the County of Los Angeles—sent out through its Bureau of Accounts and Collections of the County Department of Charities—for hospitalization costs, to cover periods of care in the Los Angeles County Hospital. In addition to such bill-bombarding, efforts are made, we have been told, to induce every patient so admitted to sign over in favor of the said County of Los Angeles liens on insurance policies or equities in real estate or other possessions, real or personal, at present held by the patients, or in the future to be acquired, and thus permit the county, presumably sometime in the future, to attempt collection in case such payment for hospitalization charges is not immediately forthcoming!

2. But even that is not all. The hospitalization charges, so made (only a few of which instances have been called to our personal attention, so that, to date, we believe no attempt has been made to contact the hundreds of former patients who have received statements for hospitalization care since July 1, 1937), in some instances must be classed as little less than stupid and outrageous! Stupid, because it is almost impossible to understand how hospital administrators of any experience, and especially those who should be familiar with the almost constant and equal assessments of the private hospitals of Los Angeles, could have been guilty of aiding in the computation of fee schedules such as have been promulgated; and outrageous, because to even well-to-do citizens in private hospitals some of these charges would be

* Editorial articles on the Los Angeles County Hospital which have appeared in previous issues of CALIFORNIA AND WESTERN MEDICINE, include the following:

Does Los Angeles County Hospital Extension Into Private Hospitals Constitute a Menace to Medical Practice? (Editorial) Volume 32, No. 2, February, 1930, page 117.

Construction and Maintenance Costs of New Unit of Los Angeles County General Hospital—What of Ultimate Results? (Editorial) Volume 32, No. 3, March, 1930, page 192.

Los Angeles County Hospital Charges Against Its Superintendent. (Editorial) Volume 34, No. 5, May, 1931, page 376.

Los Angeles County General Hospital Hearing. (Editorial) Volume 34, No. 6, June, 1931, page 421.

Osteopathic Unit of Los Angeles County General Hospital—No Longer Under the Medical Superintendent. (Editorial) Volume 35, No. 2, August, 1931, page 133.

Acute Unit of Los Angeles County Hospital: Finally in Partial Operation. (Editorial) Volume 40, No. 1, January, 1934, page 58.

The Los Angeles County Hospital. (Editorial) Volume 40, No. 6, June, 1934, page 427.

Change in Admission Requirements at the Los Angeles County General Hospital. (Editorial) Volume 41, No. 6, December, 1934, page 413.

County Hospitals Should Print Annual Reports. (Editorial) Volume 42, No. 1, January, 1935, page 40.

appalling! When such charges and demands are rendered to indigent or near-indigent citizens, afflicted not only with poverty, but, shall we say, often also with ignorance or lack of education, and, so, incompetent to understand the implied demands for money, in letters filled with legal phraseology, it is not to be wondered at if fear and worry are produced among those very unfortunates who should be free from such assault.

* * *

Detailed Information Appears on Page 97.—On other pages in this issue will be found some exhibits that shed light on what has been here stated, and members of the California Medical Association are advised to inform themselves of what is going on before their very eyes, as well as to ask if that which is being done is not a form of state medicine or worse, instituted, perhaps, without proper warrant of law? Also, whether, if continued, it must not lead to dire effects, not only upon medical practice, but upon the moral and ethical standards of the very county where such a policy of caring for California's sick indigents was inaugurated?

* * *

One Example of the Atrocious Charges for Hospitalization Care.—Space does not permit extended comment here, but one example can be cited briefly to show the preposterous and unjust nature of these charges made by the County of Los Angeles to its indigent sick; a fuller itemized statement being given on page 105, under Exhibit C.

A cesarean section having been necessary for this particular patient, charge for the use of the Los Angeles County Hospital operating room and its nursing personnel alone (the attending staff obstetricians donate their services to the county, as an expression of altruistic service to the indigent sick) was as follows:

Date	*Description*	*Charges*
October 5, 1937	Operative—Cesarean Section	$136.80
October 9, 1937	Operative—Blood Transfusion (450 cc.)	22.50

The total bill for that particular patient and new-born child for twelve days' hospitalization (that is, for food, board and nursing, because the county has no legal right to charge for professional services rendered gratuitously by the attending physicians and surgeons) was $215.41!

It may be of interest to state that the attending obstetrician for the above patient, about the same time, had a patient in the Cedars of Lebanon Hospital of Los Angeles, for whom also a cesarean section was necessary; where the operating room-personnel charge was $12.50! Contrast now this latter operating room charge (which would be about the same in every other accredited private hospital in Los Angeles) with the charge of $136.80 by the Los Angeles County Hospital, and let each physician ask himself what kind of language comes to his mind, as he would express his opinion thereon?

Attending Staff of the Hospital, Whose Members Give Gratuitous Service, Should Ask Themselves Some Questions.—As has been said, the Los Angeles County Hospital has an attending staff of 508 physicians, surgeons and specialists, practically all members of the Los Angeles County Medical Association, who give their professional services gratuitously in care of the indigent sick. Each of these attending medical men may well ask himself a number of very pertinent questions in connection with what has been stated above and elsewhere in this issue of the Official Journal. And especially so, since the annual money value of their professional services in caring for some 56,774 patients (medical and surgical care, and operations) has been estimated to be in excess of two million dollars! By contrast, the entire city of Los Angeles, a community of more than one million persons, swells with pride, and for days covers itself with glory in the newspapers, in attaining from these one million fellow citizens the sum of $2,865,654, as a Community Chest goal!

* * *

What Will Become of These Liens on Possessions of Indigents and Near-Indigents?—Naturally, with things such as the above happening, protests are being made by former patients. The retiring president of the Los Angeles County Medical Association cited the case of one former patient who was so pestered by the Los Angeles County Bureau of Accounts and representatives, seeking to make her sign over a lien for county hospital hospitalization services rendered, that she consulted an attorney, who told her to sign nothing. Unfortunately, this advice cannot be communicated to the hundreds of other indigents, in real danger of such experiences.

What is to become of all these liens gathered on the basis of Los Angeles County Hospital hospitalization? Will they later be auctioned off to tax sharks, like delinquent tax bills? And if not, why keep them and hold them over the heads of poor citizens, and so cloud title in any property they may be able to free from indebtedness? Protests have already been presented to the Public Health Committee of the Los Angeles Chamber of Commerce, and the rumbling has become sufficiently intense, at the end of six months, that the superintendent of the County Hospital has seen fit to write to the County Auditor on the subject. His letters are presented in the exhibits. They may be read, in connection with others.

* * *

A Thorough Investigation Is Indicated.—Grand Jury investigations on ways and means of conserving county resources, as well as the rights of citizens, are certainly nothing new in Los Angeles, and a thorough investigation is indicated on the basis of the evidence already in hand, and much more of which would probably be easily forthcoming, if sought. Such an investigation by an impartial grand jury committee would bring out the facts, and no doubt lead to a removal of all obnoxious elements involved.

It is our opinion that the members of the Board of Supervisors have only a casual knowledge of what is taking place in these matters here discussed, because that group of five men are responsible for a county with income and expenditures almost as large as those of the U. S. Steel Corporation, and they must necessarily depend upon their subordinates for proper administration. Somewhere, then, in all this, it is possible that there exists a case of "Bureaucracy Going Wild."

Because of the menace to the interests of the indigent sick, to the public, and to the medical profession, the offenses complained of should at once be stopped. And last, but not least, the county hospitals of California should be administered with due regard to the laws of the State, which in all this seem to be flagrantly disregarded. So much, on this vexed subject, for the present.

PLEA FOR THE PRESERVATION AND COMPILATION OF MEDICAL ARCHIVES OF COUNTY MEDICAL SOCIETIES

Lure of Medical History: William Watt Kerr, Joseph P. Widney, Philip Mills Jones.—Were you among those who read Dr. Herbert C. Moffitt's delightful sketch of one of the former guiding spirits in California medicine—the late William Watt Kerr of San Francisco? If not, you do yourself an injustice if you do not take the time and peruse it, and so enjoy the portrayal of the life of a physician whose professional work went far, in his time, in maintaining high standards of practice in our State. In addition, you will find that the article contains other interesting medical information of days gone by, which Doctor Moffitt outlines in charming style. Our medical forbears, even of so recent a period as scarcely half a century ago, loved their profession and guild with an intensity worthy of emulation by present-day disciples. Their controversies and battles, of interest even yet, were not the least of the many absorbing stories that might well find proper place in a chronicle of their periods. Doctor Moffitt's paper appeared on page 27 of the January issue.

* * *

On page 4 of the same number reference was made to Dr. Joseph Pomeroy Widney, motivating leader in the group of physicians who, on January 31, 1871, founded the Los Angeles County Medical Association, at a time when that present-day metropolis was little more than a small Mexican town. Today's members of that county society, one of the largest component county societies in the United States, may well be proud of their history, and also of their founder, who celebrated his ninety-sixth birthday on December 26, 1937, and, in spite of the heavy handicap of blindness, continues his work both as a student and scholarly author. It will probably never come to pass again, for anyone to record in the medical annals of California, that it fell to the lot of one of its physicians not only to have witnessed the great changes which have been created in the last seventy-five years in the Golden State, but also, at the same time, to have been intimately associated with, and to have had far-reaching influence in a host of civic, educational and medical endeavors that came to the front, as one decade succeeded another. Founder Widney's life has been so rich and full of service that every member of the California Medical Association may take pardonable pride in his career.

* * *

In the January issue, also, appeared a brief survey of the founder-editor of the OFFICIAL JOURNAL of the California Medical Association—the late Philip Mills Jones.* What a magnificent work he also accomplished, in his comparatively short life! Keep in mind that, in a few brief years, with a state medical journal in its swaddling clothes, and on a precarious financial foundation, his pen gave expression to views on medical journalism and ethics which the medical press of the United States, in decency and self-respect, found it could do nothing else than to adopt, thereby removing from the pages of their magazines a mass of proprietary and other advertising of unscientific products, even though at a loss of thousands of dollars to their incomes. But to Editor Jones, militant and courageous, in the righteous battle, all who transgressed were alike a foe. For that splendid service, both national and state medical societies may well be grateful to California.

* * *

Every County Medical Society Should Appoint a Committee on History, to Take Up This Work.—It is true, that only a few physicians can attain the heights reached by the men above mentioned, but the spirit of pioneers and leaders, such as the late Doctors Kerr and Jones, and our still living Doctor Widney, can be and is made part of the life of every physician who meets his professional and civic responsibilities in manner as earnest and fine as that with which these pioneers took up the consideration of each day's problems. As a matter of fact, there is not a county in this great state in which, if search were properly made, there could not be found the records of medical men who, in like fashion, have gone forth to each day's labors with outlook, both broad and gentle, dedicated to devoted service for their fellow men and patients, and to the communities in which they practiced their profession.

It is to this group of physicians, practically unknown in the sparse medical records of days gone by, as possessed by the California Medical Association, that we would direct the attention of component county societies. Before it is too late, and wherever a component county medical society exists, each such organization should appoint a Committee on History, to gather together the old record books, to secure biographical and other information, not only of former members, but of public health and similar activities in their respective communities. For better preservation, the old record books might well be sent to the central office of the California Medical Association for safe-keeping. Biographical and other sketches

* See pages 1 and 60 of the January issue.

may be forwarded to California and Western Medicine, for future appearance in its pages, or placement in the archives of the California Medical Association, for use when the needed history of our Association is compiled.

California and Western Medicine, therefore, expresses the hope that in every county society there will be one or more members sufficiently interested in the collection of historical memorabilia to lead them to present a resolution at an early meeting that would bring into being the appointment of a Committee on History, to take up this interesting and much needed work.

A. M. A. SESSION IN SAN FRANCISCO, JUNE 13–17; C. M. A. SESSION IN PASADENA, MAY 9–12, 1938

American Medical Association Session, June 13-17.—Once again, the California Medical Association will play host when, on Monday, June 13, the American Medical Association will open another five days' session, constituting its eighty-eighth annual convocation. On page 127 of this issue, in the Association news department, is given the list of local committees appointed by Dr. Howard Morrow, president of the California Medical Association and chairman, as delegated, of the Local Committee of Arrangements.

The city of San Francisco, in its handsome civic center buildings, possesses exceptionally good facilities for general and scientific section meetings, and for commercial exhibits. This year's program of papers is yet to be published in the *Journal of the American Medical Association*, but it may be taken for granted that they will measure up to the highest standards of previous years.

It is unfortunate (to make a contrast) that Los Angeles, through lack of adequate accommodations, is handicapped in so far as conventions of organizations such as the American Medical Association are concerned; for, as a matter of fact, the auditorium and other meeting place facilities of that large city are today really less serviceable and satisfactory than they were in 1911, when the American Medical Association held a session for the first and only time in Los Angeles.

It is to be hoped, therefore, that members of the California Medical Association will make note of the dates for the meeting of the American Medical Association in San Francisco, these being printed on the front cover of each issue of the Official Journal, and that a large number of physicians will avail themselves of this rare opportunity to attend, breathe the spirit of an annual session of the great national organization, and by their presence at the scientific and other gatherings partake of the stimulating, intellectual profit that is surely one of the rewards of attendance. A word, also, in regard to hotel accommodations: Members who are looking forward to attend *should request their reservations now.*

* * *

California Medical Association Session, May 9-12.—This year's annual session of the California Medical Association preceding that of the American Medical Association by about one month, will be held at the Hotel Huntington, Pasadena, commencing on Monday, May 9, and continuing for four days. The formal program will be given in a supplement to the April issue of California and Western Medicine, and, in due time, complete information concerning the scientific and other programs will appear in the Official Journal. This famous hostelry has been the scene of former sessions, most pleasantly remembered, because of conveniences made possible by the size of that hotel, and there, also, a large attendance is awaited. Requests for room reservations may be sent to the Hotel Huntington, and should be made without delay.

CALIFORNIA ATTORNEY-GENERAL'S RULING ON PUBLICATION OF CALIFORNIA MEDICAL-ECONOMIC SURVEY REPORT

For the information of members of the California Medical Association to whom the matter may be of interest, the following item from the Oakland *Tribune* of January 13, 1938, is given space:

State Medical Survey Open to All, Says Webb

Private Individuals May Print and Circulate Data, Attorney-General Holds

"Private individuals may print and circulate complete details of the $100,000 California medical-economic survey. . . .

"The way for this action was paved today by Attorney-General U. S. Webb in an informal opinion given in reply to a query from Assemblyman John Gee Clark of Los Angeles. . . .

"Webb said that there appeared to be 'no objection to printing any of the matters contained in the report, provided no incorrect statements were made in connection with the publication.'

"The accuracy proviso, he declared, would require any private publisher to designate those sections disapproved by the State Board of Health, to which the final report was submitted.

"Despite outside contributions, Webb ruled, the complete report remains the property of the State, and discretion as to what shall be contained in the official report published by the Board of Health remains with the Board of Health.

"This contention was borne out, Webb said, by a communication from Corrington Gill, Assistant WPA advisor at Washington, D. C., to James B. Sharp, coördinator of statistical projects for the WPA, in which it was pointed out that any individual might avail himself of the data."

* * *

To the informal opinion of Attorney-General Webb of California, noted above, may be added the following clarifying statement from the Federal authorities:

(COPY)

OCSP-1-11
San Francisco,
January 3, 1938.

Professor Paul A. Dodd,
Department of Economics,
University of California at
Los Angeles, California.

Re: Publication of Medical-Economic Report

Dear Doctor Dodd:

In reply to your request of December 9 relative to publication of the Medical-Economic Report, we are pleased to

inform you that under date of December 28, Assistant Administrator Corrington Gill writes as follows:

"Inasmuch as the basic data on this study are now available, there need be no question raised concerning a further analysis or interpretation of these data. It is the privilege of any individual to avail himself of published data and interpret them as his philosophy dictates, and Professor Dodd's request differs from this in no respect. . . . No clearance with the Works Progress Administration was necessary."

*This reply, we believe, will officially close the correspondence on this FERA [Federal Emergency Relief Act] undertaking in so far as the WPA [Federal Works Progress Administration] is concerned.**

Very truly yours,

WILLIAM R. LAWSON,
Administrator.

By JAMES B. SHARP,
Coördinator of Statistical Projects.

JBS:LD
CC: Walter M. Dickie
Corrington Gill
Samuel May
David M. Maynard
Howard B. Myers
Stuart A. Rice

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 125.

EDITORIAL COMMENT†

A NEW EUROPE**

Ex Oriente Lux
Ex Occidente Dux

Some years ago, a British statesman, in a speech at Johns Hopkins University, said: "Europe is dying. You can do nothing to save her. Keep clear." Was he right, or was it a mistaken prognosis? Maybe it was only an error of the sickroom. Maybe it was not death, but only a need of a change in the treatment of the case: rather would it seem that it is the civilization that is sick, and not necessarily the race. One thing is certain: Thus far, it has not proved to be a sickness unto death. Although the civilization of Europe is unquestionably threatened with dissolution, its peoples are not. They are full of vitality. It is a case where the peoples have outgrown their civilization. It is like the boy who becomes a man and has outgrown his boyish attire. To attempt to wear the old means tearing and ripping. The full grown Europe of today has simply outgrown the badly worn, youthful clothing of ten centuries ago.

Was that old civilization of ten centuries ago a mistake? Not necessarily so. The boy in man's attire would have been tripping himself in the larger garments of a man. The civilization which grew up after the overthrow of the older Latin type was suited to the age. It was the civilization of emperors and kings, of popes and priests; of the crude mechanical appliances; and of sparsely settled lands with food yet in abundance. It was an era of wars that never seemed to cease. Ambitious men fought for power and rule. It was preeminently the age of the strong man, and the stronghold; an age when the successive rulers were those of birth and not of brains.

All this has changed. Iron and coal have transformed Europe. It is now an overpopulated land of factories and shops and densely crowded cities. There are more people than the land can support. The one great cry of Europe now is for bread. And its rulers are no longer holding their office because of the glamor of birth and caste, but are taking the place of the degenerate royalty by right of brains and not birth. The caste of nobility is disappearing. The nobleman, now, is not the man with an inherited castle, with drawbridge and moat; but the man who does things, who brings things to pass. The old is passing. It is the time of rebuilding.

But the old does not give up peaceably; and would-be strong men, fired by ambition, foment strife. And there are not many men who, like Aristides and Edward VIII, go quietly into exile. The lust for power is strong. The ability to use it is too often weak.

What can be done to make the transition from the old to the new one of peace, and a peace that shall abide? Much of what follows I have already told in the chapter on "World Problems," in my work, "The Rebuilding of a Wrecked World Civilization.‡ I recount it for a purpose: to aid in the rebuilding of the wrecked civilization of Europe.

These changes must be, if the future is to hold a better fate for Europe than the past:

First: There must be a realignment of Europe upon racial rather than upon national lines. Let there be no more dynamite storehouses like Austria, with its seventeen different peoples and tongues. Let *like* seek and ally itself with *like,* racially: Engle Man of the North Seas with Engle Man; Teuton with Teuton; Latin with Latin. And the unstable Celt—like the Galatians over whom Paul lamented—mingling and losing himself in all, but furnishing the music, the artistic inspiration, the well springs of literature, to all, as his contribution in the building up of a new world humanity.

Second: There must be a line of absolute division between religion and the civil life of humanity. The monastery and the Pontiff Maximus of Rome did their work, and did it well, in the upbuilding of the Mediaeval civilization of Europe; but in the upbuilding of a new civilization they are as much out of place as the mammoth or the cave bear or

* Editor's Note.—Italics our own.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

** The author of this essay is Joseph P. Widney, M.D., D.D., LL.D., founder of the Los Angeles County Medical Association, who attained his ninety-sixth birthday on December 26, 1937. (See January CALIFORNIA AND WESTERN MEDICINE, page 4.) Biographical data concerning Doctor Widney were printed in CALIFORNIA AND WESTERN MEDICINE, April and May, 1936, on pages 292 and 396.

‡ For review of this book, see CALIFORNIA AND WESTERN MEDICINE, December 1937, on page 367.

saber-toothed tiger. *Requiescat in pace mortuorum.* The new civilization must have no religious wars. Civically, it must be neither for nor against religion. Each man, whether "infidel" or believer, must be free to settle with God for himself.

Third: No closed seas and no hostile fleets must ever separate the races from the field of their food supply. The future food supply for Europe is to come from Africa. The unused and arid lands of that continent must be equitably divided for reclamation and cultivation; and no Gibraltar-Suez line must ever intervene. The Mediterranean, in peace or in war, must cease to exist as a barrier between kitchen and storehouse. And no transverse line from Sicily to Tunis must divide East from West. The Mediterranean must be made a free highway for all races.

I have written, in the work to which reference has been made, of other problems which a rebuilt world civilization must face. These that I have now written are the problems of a rebuilt Europe. And Europe must face them or die.

3901 Marmion Way.
August 20, 1937.

Joseph P. Widney,
Los Angeles.

HOSPITAL RADIOLOGISTS AND PATHOLOGISTS

The California Medical Association has now come out in favor of having doctors who practice radiology and pathology rent space (and equipment) of hospitals instead of having the hospital hire the doctors.[1] Two very enlightened men—one a radiologist, the other a hospital administrator—laid the groundwork of principle for this plan, and other enlightened men are adhering to these principles.

We are aiming to better the care of sick people. It is necessary that doctors do well enough financially so that able minds may be attracted to medicine as a career. It is necessary that hospitals make a financial success or decent hospital care will cease to be available. What magic is there in a particular type of financial arrangement between a hospital and a doctor (radiologist, pathologist) that will better the lot of both of them?

The matter would seem to rest at bottom on the professional side. The opportunity to cultivate his career for his own professional and financial advancement ought to attract as able men to hospital quarters as to downtown offices. There would be a displacement of a couple of types of laboratory specialists that one still sees often in hospitals, namely, the one not able or not experienced enough to stand on his own feet, and the one whom economic necessity forces to give first attention to his downtown office, leaving the hospital in the second place.

An able man building his own career in hospital quarters will pick up the responsibilities that go with this freedom. He will be always in the one place—his hospital office, which will encourage the staff doctors to ask him personally about findings and proposed examinations. His work will be tied to his name, his services will be of a doctor to other doctors and their patients. Criticisms of his work will come direct to him and not to the hospital management. Doctors will tell the radiologist to send for a patient and examine her chest, instead of telling the floor nurse to "get a chest x-ray." This gives him a chance to find out what is being searched for and an opportunity to mobilize the resources of his specialty. If he can make his examinations more helpful, he will be more often called upon. If he has unique abilities, patients will be sent even from downtown to make use of them.

The hospital staff, seeing more intimately the work of pathologist and radiologist, might voice their conviction as to whether Dr. A or Dr. B is good enough to be allowed to rent space in their hospital.

The radiologist renting space will be courageous in investing in new equipment, even more than where it devolves on the hospital, for he will have not only the need to keep his department technically efficient, but also to advance himself professionally.

It is not that the pathologist and the radiologist will do perfectly when "on their own." They will make all the usual mistakes of doctors. Availing themselves of permission to collect their own bills, they will likely pile up uncollectible accounts in a way no hospital business manager would tolerate. Yet even this shortcoming, being a mark of freedom, ought to be cherished. It is still permitted, we believe, to hold for the private practice of medicine.

As pathologists and radiologists do take on this recommended rental arrangement with their hospitals, and so gain opportunity to build themselves *in a hospital* a real medical career, they will have to conduct themselves like doctors, not technicians. They will have to get their shoulders under the responsibilities of caring for sick people. They will have to look as closely at their patients as at their shadows and effluvia. They have the opportunity of teaching the well-to-do to pay well and like it—and the duty of caring for the dead-beat for nothing, and liking that (or pretending to with as good grace as may be).

Theirs will be a difficult career. They will have to satisfy their patients, who do not know what is good medicine and what is bad; and also to convince their referring physicians, who do know or ought to.

Anyhow, here is opportunity—the possibility to develop in hospitals radiologists and pathologists who are not just doers of medical chores, but who can cultivate careers in which they can really take pride.

And when they have made a success they will be able to afford to pay their hospital a rental not inferior to what the hospital nets from its rooms. Moreover, the presence in the hospital of these successful specialists will prove attractive to the staff, whose patients make the hospital's prosperity.

The report refers also to university hospitals. The obligations and opportunities of teaching and

1 California and Western Medicine, 46:419, June, 1937.

of leadership only accentuate the considerations already commented on. A pathologist or radiologist who accepts a straight salary, turning the fees from his practice into the school funds, may feel well repaid by the opportunities for research and some relief from the necessity to cultivate a private practice in order to make a living. But what a medical school does must have an influence on what the medical profession will take as acceptable. Schools ought, one would say, to lead as well as to point the way to what is best in the practice of medicine in general.

Stanford University Hospital.

ROBERT R. NEWELL,
San Francisco.

NEONATAL MORTALITY IN SAN FRANCISCO*

For the past decade the infant mortality rate in San Francisco has steadily declined. In 1934, the rate dropped to an all-time low of thirty-three per one thousand live births from thirty-nine in 1933, at which point it had been stationary for two years. A slight rise to thirty-five was seen in 1935, and a marked increase to forty-two occurred in 1936, the circumstance surrounding which rise having previously been described.[1]

NEONATAL PERIOD USED IN THIS STUDY

In San Francisco, as in other cities, the majority of the infant deaths occur in the neonatal period, which for the purposes of this study was considered under fifteen days. Other factors which vary from year to year influence the total rate, but over a period of ten years the neonatal death rate has been practically stationary. It was with this fact in mind that the present study was undertaken in order to determine, if possible, what factors were present in maintaining the rate level. Could this rate be reduced or had we reached that theoretical point called the irreducible minimum?

SAN FRANCISCO HOSPITAL FIGURES

It may be of direct interest to point out that the Department of Public Health, through the San Francisco Hospital and its out-patient obstetrical department, delivered in 1933, altogether, 18.2 per cent of the total births that occurred in San Francisco. In 1934, the same agencies delivered 15.5 per cent; in 1935, 14.2 per cent; and in 1936, 11.2 per cent. This reduction is quite remarkable, and is perhaps the most sensitive index to the return of a better economic era.

It could be further pointed out that the ratio of births delivered by these services of the Department of Public Health and the low mortality rate of thirty-three in 1934 may be of some significance. Likewise, the rising infant mortality rate which has occurred in the city and county of San Francisco since 1933 and the decrease in the number of births delivered by the services of the Department of Public Health may be equally significant. It is desired to state, however, that no criticism is intended of the private physician, nor any credit assumed for the excellent record of the departmental services, because it is realized that the pregnant woman, in selecting a physician, quite often materially delays the decision and, in our experience, the private physician does not see the case as early as the out-patient clinic of the Department of Public Health.

For the past six years the out-patient obstetrical service of the Department of Public Health has performed the Wassermann test on all pregnant women coming under its supervision. It may be of additional interest to show that the percentage of positive Wassermann tests has averaged approximately 4 per cent.

NEONATAL DEATHS STUDIED

A total of 231 neonatal deaths occurring between January 1, 1936 and April 30, 1937, were studied. These represent a typical section out of any period in the last decade with reference to the relative

* From the office of the Director of Public Health, City and County of San Francisco.

1 "Infant Mortality in San Francisco," California and Western Medicine, Vol. 47, No. 2 (Aug.), 1937.

TABLE 1.—*Premature Birth (159*)*

Cause of Death	Autopsy			No Autopsy		
	Male	Female	Total	Male	Female	Total
Prematurity	18	7	25	31	21	52
Atelectasis	13	11	24	8	11	19
Preëclamptic toxemia	..	..	..	0	3	3
Asphyxia	..	..	..	3	0	3
Enteritis-diarrhea	1	1	2	0	2	2
Acute yellow atrophy of liver	..	..	..	0	1	1
Convulsions	..	..	..	0	1	1
Respiratory infections	1	1	2	1	1	2
Hemorrhagic disease new-born	1	0	1	..	..	..
Totals	34	20	54	43	40	83

* International List No., 1930.

TABLE 2.—*Congenital Malformations (157*)*

Cause of Death	Autopsy			No Autopsy		
	Male	Female	Total	Male	Female	Total
Congenital malformations of heart	4	2	6	4	2	6
Atelectasis, asphyxia	1	1	2	0	1	1
Marasmus, enteritis	0	1	1	..	..	..
Bronchopneumonia	1	0	1	..	..	..
Other congenital malformations:	..	..	..	..	..	..
Spina bifida, meningocele	1	0	1	..	..	..
Palate, enlarged thymus	1	0	1	..	..	..
All other malformations	0	3	3	2	3	5
Totals	8	7	15	6	6	12

* International List No., 1930.

incidence of the several classifications. Of the 231 deaths, 132 were males and 99 females. Diagnosis was confirmed by necropsy in 101 instances, or 44 per cent of the total.

CAUSES OF DEATH

The greatest cause of death among the neonatal group is prematurity (Table 1), which was responsible for 137 in this group, of which seventy-seven were males and sixty females, and of which fifty-four, or 39 per cent, came to necropsy. Prematurity as a cause of death is given preference when reported jointly with certain other causes, and Table 1 indicates the joint causes appearing in the group studied. In twenty-five cases that came to necropsy the cause of death is prematurity alone. In twenty-nine other necropsies in the premature group, additional causes were found. The postmortem findings in this group of fifty-four, of course, would have to be reviewed with considerable detail in order to determine what caused the deaths to be diagnosed as premature.

Pathologists themselves are quite willing to admit a certain percentage of unsatisfactory results in this group. Much too frequently they are compelled to rely on the history and the measurements for the diagnosis of prematurity, for the simple reason that prematurity *per se* does not leave any recognizable changes at necropsy; and prematurity is given as the sole cause of death, because no sign of tissue change which would cause death is found. The theory advanced by some that these deaths are physiochemical in character offers a field for investigation which as yet is relatively untouched.

The second important group of neonatal deaths, according to the International Code, is congenital malformations. A total of twenty-seven makes up this group (Table 2), with fourteen males and thirteen females, of which number fifteen, or 55 per cent, came to necropsy. These causes are self-explanatory and require no comment, as, naturally, they originate *in utero*. The relatively high percentage of necropsies in this group is significant,

TABLE 3.—*Injury at Birth (160b*)*

Cause of Death	Autopsy			No Autopsy		
	Male	Female	Total	Male	Female	Total
Injury at birth	0	1	1	..	..	..
Cerebral hemorrhage	2	0	2	..	..	..
Edema of larynx	..	..	..	1	0	1
Asphyxia	..	..	..	3	0	3
Atelectasis	..	..	..	0	1	1
Cerebral hemorrhage	2	2	4	2	3	5
Hemorrhagic disease, asphyxia	..	..	..	0	1	1
Enlarged thymus	1	0	1	1	0	1
Prolonged labor, version delivery, cord prolapse	..	..	..	0	1	1
Tentorial tear	1	0	1	..	..	..
Atelectasis	2	0	2	..	..	..
Breech presentation	1	0	1	..	..	..
Totals	9	3	12	7	6	13

* International List No., 1930

TABLE 4.—*Other Causes*

Cause of Death	Autopsy			No Autopsy		
	Male	Female	Total	Male	Female	Total
All other causes:						
Atelectasis	1	0	1	1	0	1
Difficult labor	0	1	1	1	1	2
Asphyxia neonatorum	2	1	3	4	1	5
*Gastroenteritis	1	1	2	..	..	..
Bronchopneumonia, otitis media, mastoiditis..	1	0	1	0	1	1
Bronchopneumonia	1	0	1	0	1	1
*Bronchopneumonia	1	2	3	0	2	2
Icterus	1	1	2	1	1	2
*Pneumonia, interstitial, septic infarction lungs..	1	0	1	..	..	..
*Acute tracheitis	..	..	..	0	1	1
Pemphigus neonatorum	..	..	..	2	0	2
Malnutrition	..	..	..	1	0	1
*Acute toxic nephritis, anasarca	0	1	1	..	..	..
*Volvulus, small intestines	1	0	1	..	..	..
Hemorrhagic disease of newborn	1	0	1	..	..	..
*Streptococcic meningitis, predelivery infection of child	0	1	1	..	..	..
*Status lymphaticus	..	..	..	2	0	2
*Streptococcic peritonitis	1	0	1	..	..	..
*Cancer metastatic	..	..	..	0	1	1
Baby did not breathe at birth (lived six hours)	..	..	..	1	0	1
Totals	12	8	20	13	9	22

* Classified outside of diseases peculiar to early infancy (161).

suggesting the possibility that in the presence of a recognizable abnormality the curiosity of the attending physician is aroused and extra pressure is exerted to secure a necropsy.

The third group classified is one which may lead to considerable misunderstanding. The heading in the International Code (160 B), "Injuries at Birth," lists as a subheading, cerebral hemorrhage directly as a result of injury; also, in the same division, cerebral hemorrhage from any cause whatsoever without reference to injury. Many instances of cerebral hemorrhage are entirely unrelated to trauma as an etiologic factor, and the classification of such deaths under the general heading, "Injuries at Birth," is misleading. In the group studied (Table 3), there were twenty-five deaths, of which sixteen were males and nine females, with twelve necropsies, or 48 per cent. The need for very careful reporting of these deaths, and especially the need for a greater percentage of postmortem studies in this group, is apparent if the present situation is to be clarified.

The fourth group (Table 4) does not follow the International Code classification because there is only one death (occasionally two or three) listed under each cause. Some of these causes come under the heading, "Other Diseases Peculiar to Early Infancy," and others marked (*) have a classification of their own; but, with twenty causes of death among forty-two deaths, the number in any group is too small to be of significance. Attention is called, however, to the evident fact that those diagnoses without necropsy mean very little from either a statistical or pathological point of view. As in Group 3, there were 48 per cent that came to necropsy.

SUMMARY

1. Neonatal deaths among male infants are more numerous than among female infants in the ratio of approximately 132 to 100. Compared with the birth ratio of 106 to 100, this is an actual as well as a relative high death rate among male infants.

2. A definite need exists for the further investigation by physiochemical studies of the premature infant, both antemortem and postmortem.

3. Except in the premature group, diagnoses without necropsy are always open to question and, if reliable information is to be secured, a greater number of carefully recorded necropsies must be performed.

4. Careful reporting to the local registrar and health officer of the cause of every neonatal death should be the first duty of the physician.

101 Grove Street.

J. C. GEIGER,
P. S. BARRETT,
San Francisco.

ORIGINAL ARTICLES

THE CRIMINAL INSANE*

By Ruggles A. Cushman, M.D.
Talmage

Discussion *by Edward W. Twitchell, M. D., San Francisco; A. M. Kidd, Professor of Criminal Law, Berkeley; Milton B. Lennon, M. D., San Francisco.*

THE term, "criminal insane," is commonly applied to public offenders who are suffering from psychoses or from mental deficiency. There are about four hundred of this class in our California state institutions, about three hundred of whom are confined in the Mendocino State Hospital, which has been semi-officially designated the hospital for the criminal insane; one hundred, of various degrees of mental disturbance, in the State penitentiaries; and the remainder, most of whom have committed minor offenses only, scattered throughout the remaining state institutions. How many are still at large we cannot tell, nor how many border-line cases there are in the penal institutions and jails.

"CRIMINAL INSANE": ITS MEANING

To the psychiatrist and the jurist, through whose hands these four hundred or more have passed, the term "criminal insane" means something different from this general conception, or, perhaps we should say, means nothing, and is just a loose and convenient combination of words. From the psychiatric point of view these people do not differ from any other group of mental patients of like number. Some come to the State Hospital from Tehachapi, Folsom, and San Quentin, having been diagnosed there as mental cases, after conviction; some come from the various counties before trial, because they have been found legally insane and so not subject to trial until recovery. But the majority of them come after trial, when they have been adjudged not guilty by reason of insanity. To the psychiatrists at the hospital they are like other patients, except that they arrived under a different kind of commitment, and they are treated like the others, except for the extra caution used to prevent their escape.

From the legal point of view, the term "criminal insane" is wholly inconsistent, and has even less significance. As a legal principle, one cannot be insane and a criminal at the same time. An idiot and an insane person cannot commit a crime, the law declares, but adds in effect, "The law is going to define what an idiot or an insane person is, however, and not the psychiatrists."

BETTER CLASSIFICATION NEEDED

The "criminal insane" classification is loose and inadequate, both from the psychiatric and legal point of view, and should be replaced by a more scientific phrase, just as the term "insanity" has been discarded in psychiatry because it is no longer adequate to include all the facts and theories which have developed in that field. For the purpose of this paper, we will now use the expression as embracing all that class of psychotics and mental deficients who reach our public institutions through criminal-court proceedings.

It is in these proceedings that the conflict between medical and legal conceptions of mental disease is displayed so noticeably. The disadvantage is all on the part of the psychiatrist, because he must conform to the law, not the law to the psychiatrist, and because the law is out of step with modern psychiatry.

We can see how complete this disadvantage is when we consider that even though the prisoner whom the psychiatrist has been requested to examine is found to be definitely psychotic, and though opposing counsel, the judge, even the jury, accepts his diagnosis as correct, still, according to law, the defendant may be found sane, perhaps sentenced to hang. On the other hand, a defendant may be found not guilty by reason of insanity when all the alienists on both sides have testified he has no psychosis.

PSYCHIATRIST IN COURT PROCEEDINGS

At the various stages in a criminal proceeding, the psychiatrist, who is examining the prisoners, discovers that none of them is there for the primary purpose of making a diagnosis, but rather he must ever be vigilant in preparing himself to answer questions of fact upon which he will be cross-examined in court, and which are concerned not with psychiatry, but with lay tests formulated by courts and jurists centuries ago. Further, he must be prepared to face a different line of quizzing for every stage of his examination.

For example, at one stage of the trial, the test of the prisoner's sanity is whether he is capable of making a rational defense; at another, whether he is capable of understanding why he is being punished; at another, whether he knew what he was doing when he committed the offense, and if he did, whether he knew the act was wrong; and so on; for the law's definition of insanity shifts in different proceedings and at different stages. The test is never, whether the offender had or has dementia praecox or paresis, or some other such classification, questions in which the law has no interest except as they throw light on these lay and highly metaphysical matters.

WEAKNESSES IN THE COURT PROCEDURE SYSTEM

As one result of this condition, we receive these offenders in the state hospitals, not on the diagnoses made by the alienists at the trials, but on replies made by them to these test questions, about which they are little more capable of judging, distinguished authorities though they may be, than anyone else. To add to the farce, a lay jury weighs this evidence, and makes the final diagnosis of "guilty" for the sane, or "not guilty" for the insane; and so no wonder the psychotics often go to the penitentiaries and the malingerers to the

* From the office of the superintendent, Mendocino State Hospital, Talmage, California.
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state hospitals. Also, not surprising that dangerous criminals get by with pleas of insanity, a year at the hospital, then release to prey upon society again. For this release the hospital authorities are usually blamed, though they have no legal right to hold them longer.

Another court proceeding which brings the psychiatrist into popular disrepute is the manner in which he must testify as an expert. Testifying on the opposing side perhaps are other experts. Because of this fact, and because, in border-line cases such as most of these defendants are, these experts disagree in their opinion, the public often insists such opinions are bought. While it is true, as in every trade or profession, there may be this venial type, it is far more true and common in practice that what the psychiatrists are disagreeing over is not the medical diagnosis but these non-medical questions which are put to them and which they are trying conscientiously to answer, such as "What is right?" "What is wrong?" "Did this defendant know he was doing wrong?"

REMEDIAL LEGISLATION NEEDED

Now all this may seem like a heavy criticism of our courts of justice, but it is not so intended and will not be so understood if we recognize that our penal system is based on the doctrine of responsibility for our acts. The only two large countries which have overthrown this doctrine of individual responsibility entirely are the State of Mexico and Soviet Russia. For the sake of providing a proper defense of these four hundred more or less unbalanced offenders, we would not desire to overturn our criminal courts. All we desire is remedial legislation. This system has its faults, among which are those I have related, but it is the solid foundation upon which our present social and moral life is built. It was a long step in advance when, upon this doctrine of responsibility of every person was grafted the new principle, that insane persons are not responsible and cannot commit a crime. The next step is for psychiatrists and jurists to come to a better understanding as to what insane people are. The difficulty is not that juries and the legal profession as a whole do not wish to meet the psychiatrists halfway. It is in accomplishing this purpose without infringing upon this doctrine of free will and responsibility, and without taking away a prisoner's constitutional right of trial by a jury of his peers, and superseding it with a trial by a jury of psychiatrists.

PROCEDURE IN CALIFORNIA

In short, the conflict between the two professions is a technical one chiefly, and not one of principle. California, we are proud to say, is one of the leading states in this effort toward reform, though there is still so much to be done. Our more eminent judges use every means within the principles and rules of present law to give the courts and juries the benefit of the judgment of the psychiatrist, and make use of his knowledge. California is one of the few states which has enacted a law making it the duty of the judge, when a defendant pleads "not guilty by reason of insanity," to appoint one or more psychiatrists as friends of the court to examine the prisoner, the theory being that such an appointment will preclude any question of bias on the part of such alienist and his testimony will thus become more valuable.

Also, many judges are commencing to see the value of sorting out the mentally unsound defendants before trial, rather than going through the ordeal of trial by a lay jury and having them found guilty, sent to the penitentiary and from there to the hospital, as often happens; and also doing away with the expense of a trial. This is a procedure that is specially urgent, and can be done without any infringement on any present law.

Also, our courts in California are inclined to discourage the determination of a defendant's sanity by the use of the hypothetical question on the witness stand, whereby an alienist draws his conclusion and makes a so-called diagnosis from the outline of the history of the case in a question drawn up by the attorney examining him. The tendency now is to provide for the examination of the prisoner himself by the alienist, the advantages of which are readily understood.

THE "1026 LAW"

An effort at reform was initiated by the Legislature and approved by the courts, but from the point of view of the psychiatrist it has proved far from successful. This is the so-called "1026 law," whereby under this section of the Penal Code a defendant must offer his plea of "not guilty by reason of insanity" as a separate plea, while formerly this question was tried along with his "not guilty" plea. If the jury finds him not guilty by reason of insanity, this law provides he shall be committed to a state hospital for one year, unless it shall appear to the court he has fully recovered his sanity. At the end of the year he may apply for release. If at the hearing he is found to be still insane, he is returned to the hospital. If recovered, he is discharged. He cannot apply for release again for another year if he is found to be still insane, and so on, yearly.

The purpose of the enactment was, doubtless, to prevent a defendant from walking out of the courtroom a free person after acquittal, and often a dangerous one; or if committed to a hospital because his insane condition still exists, to prevent him from applying for a writ of habeas corpus at once, and so securing release.

The principle seemed reasonable, but what has been the result? For one thing, this new law acts as an invitation for every criminal to use the special plea. Nothing is lost by making the plea and a great deal may be gained, for the matter of his guilt has already been tried. These defendants are usually border-line cases, often downright malingerers, or sometimes, persons actually sane for whom the juries feel a certain sympathy, so that they wish to ease down on the punishment by providing a year in the hospital instead of a term in the penitentiary. For, if the defendant has a well-defined psychosis, the judge will in all probability, on his own initiative, have a hearing on the prisoner's sanity before the trial for his offense,

and send him to the hospital, since a prisoner cannot be tried while insane.

On their successful plea of insanity, these individuals reach the hospital and at the end of the year they apply for release. Unless suffering from a definite psychosis, the hospital staff can only testify that they are sane, and the judge is bound to release them. So the problem of the abuse of the plea has not been solved, merely dumped into the lap of the state institution officials and the judge who must sign the discharge, against all of whom there is much public dissatisfaction expressed.

HOW THE LAW WORKS OUT IN PRACTICE

It is a common occurrence in the Mendocino County courtroom, where most of these applications for release are heard, for the witness to testify that he feigned insanity at his former trial, even show how he did it, and so the judge is forced to discharge him, since there is no evidence of insanity on which to hold him. This is no reflection on the psychiatrists who examined these defendants prior to their commitment, for they were committed upon the verdict of a lay jury. Further, the diagnosis of the examining physicians is usually based on a few hours' observation, when it should be at least a month's observation. It is made under the most unsatisfactory conditions, while these border-line cases and malingerers have usually spent a goodly share of their lives passing in and out of hospitals and penal institutions, and have an actual technique which they pass on from one to another, for getting into hospitals instead of jails and penitentiaries. In addition, is the problem of being compelled to keep these sane criminals in the hospital for the required year, as they are all potential escapes.

LAW SHOULD BE AMENDED

For these reasons, we feel that the law should be amended and supplemented by provision that, before a prisoner is tried upon his insanity plea, he shall be sent to a state hospital for one month or longer, if possible, for continued observation. If found actually suffering from a mental disease, he could be detained until recovery without the expense and ordeal of a trial, and then be tried on a fair basis. If found sane by the hospital staff, his opportunity for escaping by means of an insanity plea would not be so favorable. Also, justice would be done to that type of offender who is actually suffering from a psychosis, but who, due to popular feeling against his anti-social act, is often dealt with most unjustly.

Colorado, Ohio, Maine, Vermont, and New Hampshire have such a law, committing the defendant to a state hospital for observation if he pleads insanity as a defense. Colorado and Ohio provide that the detention shall not exceed one month's period; Maine and Vermont provide that the judge may (not must) order the defendant into the care of the hospital superintendent "until further order of the court, that the truth or falsity of the plea may be ascertained." New Hampshire has a similar law. Experience in other states having proved such legislation practical, an attempt was made to introduce a similar law by a bill submitted at the last session of the Legislature here in California. But the attempt was unsuccessful, though we are hoping it may be accomplished next term.

OTHER REFORMS

There are other reforms which it is hoped may be introduced into the California law, with a view to bringing it more into step with modern psychiatry. The legal court test of insanity in a trial for an offense in this state is whether the person was so disordered in mind when he committed the act as not to know the nature and quality of it, or if he knew this, did he know that the act was wrong? The answer to these questions by the psychiatrist must be "yes" or "no." The defendant must be found either responsible and, therefore, sane or irresponsible and, therefore, insane, to meet legal requirements in most of our states, including California.

In some states the test has been modified to include the test of the defendant's volitional powers, the so-called "irresistible impulse" test; in some states the doctrine of partial irresponsibility is indirectly accepted, but only in mitigation of punishment, when records or testimony may be presented to the judge after trial and before sentence. A famous case where this was done was at the Loeb-Leopold murder case in Chicago. In California, as in most states, it is not permissible. Also, in California and most states, a person with insane delusions is legally sane and irresponsible in spite of them unless the facts of the delusion, if true, would justify a reasonable man in committing the offense. That is, a person with delusions is guilty unless he acts like a reasonable man! There are other tests which time will not permit us mentioning, but which are in need of modification. Back of all these efforts at change is a desire to amend the old conception that man is all conscience and intellect, and give recognition to the compelling power of the emotions, just as modern psychiatry is doing.

THE MASSACHUSETTS LAW

This paper would be incomplete without a paragraph concerning the Brigg's Law of Massachusetts, which we hope may be a pattern for a similar law in this State. It is based on the principle of an automatic examination for all persons who have committed major crimes, and for recidivists. This examination is made by the psychiatrists who are appointed by a professional organization—the Department of Mental Diseases of the Commonwealth—and who are both representatives of the court or of either party, thus removing the report from suspicion of bias. The records are kept by the State Board of Probation, and are accessible to the District Attorney, attorneys for the defense in any trial, and, of course, the judge. They also reach the jury, as the examining psychiatrists may be summoned by either the defense or the prosecution. The statute is worded so that the question of whether the mental disease would affect the subject's criminal responsibility is decided in advance of the trial. If the defendant is found to

be suffering from mental disorder, he is immediately committed to a hospital until his recovery. Some of the advantages are elimination of a trial by jury when the psychiatrists pronounce the offender insane, savings to the State in expense of trial, lack of opportunity to feign insanity, plenty of time for observation on the part of the examining psychiatrists, and humane treatment of the insane criminal. Such a change in our law would also benefit that type of defendant who, though pronouncedly psychotic, shows no symptoms to the lay mind, so that even his attorney oftentimes does not suspect his condition and advises a plea of insanity. Thus, a victim of ignorance, he may plead guilty or be found guilty wrongfully. Mr. Winifred Overholser, Commissioner of the Department of Mental Diseases of Massachusetts, just resigned, has issued a most interesting booklet of the operation of this law. The Criminal Law Section of the American Bar Association has recommended that the scope of the statute be extended to include all felonies. We, who are specially interested, hope its principles may be enacted into the laws of our State.

I have desired, in this paper, to point out a few of the difficulties the psychiatrist must meet when called upon to examine offenders and testify in court concerning their mental condition; and to suggest a few much-needed reforms.

IN CONCLUSION

In conclusion, I would ask that you give all the assistance you can to the efforts being made to induce the Legislature to support these reforms; particularly the enacting of a law providing for the examination of the offenders pleading insanity by psychiatrists with plenty of time for observation at a state hospital. I have attempted to show the special need for this legislation, and, with sufficient support and interest, it can be accomplished. I thank you for any coöperation you can give and for the considerate attention you have shown me today.

Mendocino State Hospital.

DISCUSSION

Edward W. Twitchell, M.D. (909 Hyde Street, San Francisco).—It is quite true that the term "criminal insane" lacks in many respects of being perfectly suitable. That is true of a great many terms in common use, but they are continued until an acceptable substitute is found.

While it may be true, from a legal point of view, that the term is inconsistent and that, legally, one cannot be insane and criminal at the same time, in actual fact it is true that one can be insane and criminal at the same time. There are many insane, even insane who are in state hospitals, who in spite of their psychotic condition, if the term "insanity" be objected to, have an excellent understanding of what is right and wrong, and are able to control themselves so far that they refrain from doing wrong. There is many a paranoid who believes himself to be persecuted, but does not attack his persecutor because he feels it wrong to disobey the laws; while, on the other hand, there are those who are quite aware that their mental condition is a protection to them and would take advantage of it to commit all sorts of illegal acts. The vast majority of the insane, of course, are without the ability to reason correctly and are admittedly irresponsible.

The duty of the psychiatrist in court is to aid the court and the jury to determine this responsibility or irresponsibility. The method at present in use in this State is not calculated to give the courts the aid that they need. It was thought a great step had been taken forward when judges were ordered, in all cases of doubt, to appoint three psychiatrists to examine the accused who pleaded not guilty by reason of insanity. This is correct in purpose, but it does not always work out well in practice because, for one thing, judges are not always good selectors of psychiatrists. The judge may think his personal friends are excellent psychiatrists, while actually they may be incompetent, and though, as is mandatory, one of those selected must be from the staff of a state hospital, not every member of the staff of a state hospital is necessarily a good forensic psychiatrist. The result is often that the commission of three is entirely dominated by one who is followed obediently and blindly by the two others.

Even if the commission were all your fancy paints, this commission has inadequate time and opportunity for examination. The attorney for the defense has told his client, under no circumstances to permit examination by the doctors appointed by the court, so the doctors appointed by the court must report without having had opportunity to make any sort of physical examination or even a proper mental examination, and their opportunity for getting family and past history may be so small that they are practically ignorant of the prisoner's antecedents and personal history. The attorney for the defense will not permit this examination because he regards the doctors appointed by the court as too close to the district attorney, and he will not trust the district attorney. Experience has taught him that district attorneys are not always to be trusted. Two ways out of this difficulty have apparently been found: one in the Briggs law and the other the Colorado procedure, where the patient is put for a month in a state psychopathic hospital for observation, that the staff may report to the court at the end of this period of examination. As compared with our present-day methods, there is no question that either one of these is preferable to our own.

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A. M. Kidd, Professor of Criminal Law, University of California, Berkeley).—Ideal legislation on the subject of insanity as a defense to crime presents constitutional problems, as well as the difficulties of persuading the people that it should be adopted. There is, however, a practical solution, which should work pretty well, utilizing the law as it now stands with very little change. Accept the right and wrong test to its fullest extent. Practically every defendant who comes before the court possesses that minimum. In fact, there are very few inmates of the state hospitals for the insane who do not know that the common crimes are forbidden by law. Those who are obviously so far mentally alienated that they do not know the difference between right and wrong are not tried. The judge and the district attorney recognize their condition, and send them to a state hospital. As Doctor Cushman says, "If the defendant has a well-defined psychosis, the judge will in all probability, on his own initiative, have a hearing on the prisoner's sanity before the trial of his offense and send him to the hospital, since a prisoner cannot be tried while insane." With a month's observation, as Doctor Cushman recommends, the result would be a larger number of cases sent to the hospital without trial.

In the cases that are tried, the defendant can and should be convicted. The evidence of a psychosis, unless it goes to the length of establishing that the defendant did not know that what he did was contrary to law, should be of no importance on the trial. Something has been made of the theory of the power to choose, but, as has been said: "Whatever the compelling power of the emotions, the defendant still knows what is right and what is wrong according to law. The absolutely irresistible impulse is an extreme abstraction." By applying the right and wrong test literally, practically every defendant who comes to trial would be convicted and would be detained for an indefinite term with a high maximum, for the maximum penalties in California are very high.

Moral responsibility is a theological question to which the law can give no answer. Unquestionably, the man with bad heredity and environment, suffering from a psychosis, even though he knows the law of the land, is not as responsible as the winner of the Eugenic Prize. But the law can do nothing about this difference. The fact is that the former is dangerous to society and the latter is not.

The next important step is to hold in an adequate institution for the criminal insane, those who have definite psychoses and would be benefited by their treatment in such an institution. In 1905, an institution for the insane person charged with felony was provided for by an act of the legislature. The building was started, but not completed. The location was at Folsom, an obviously undesirable place. A suitable building in a suitable location should contain a block of maximum security cells and detention places down to minimum security, according to the condition of the patient. Doctor Cushman and an architect would have no difficulty in designing such an institution. The present hospital at Ukiah is not equipped for persons with criminal tendencies and the ability to escape, and too many of the staff are political appointees. Much of the criticism of the present law arises from that fact. Not so many years ago a defendant, a colored man, was found insane and sent to Ukiah. In a few weeks he was back again before the same judge. The judge asked for an explanation. The defendant gave it. "I was in the yard and an attendant came up and says to me, 'Nigger, you ain't crazy.' 'Why, yes I is,' I says. 'See here, Nigger,' says he, 'I am going away and I am not coming back for fifteen minutes. If you are here when I get back, then you *are* crazy' and, Judge, when he came back I wasn't there."

An institution, properly built and staffed, would solve most of the problems, with no change in the law. The solution does not differ substantially from the English law. There the jury is permitted to find the defendant guilty of the act, but so insane as not to be responsible according to law. The court then orders the prisoner to be kept in custody as a criminal lunatic until His Majesty's pleasure shall be known, and His Majesty is pleased not to release him. The result is that the defense is rarely made by defendants except in capital cases. A conviction for robbery or burglary involves perhaps a two- or three-year sentence to prison, but a finding of guilty but insane means detention for life.

If the medical experts knew that a defendant found guilty under a right and wrong test would be put in an institution for the criminal insane if suffering from a psychosis and in such institution would be cured, if possible, otherwise detained for the maximum term, there would be less reluctance to find the defendant sane according to the law. Under the law as it is at present, the experts for both sides, if reasonably competent, usually agree as to what is the matter with the defendant medically, but the prosecution experts say he knows the difference between right and wrong in relation to the law of the land as applied to the act that he did. The defense experts say that may be so, but a man so seriously diseased ought not to be sent to prison. The absurd hypothetical question makes a difference appear between the experts, where there is none in fact. The defense counsel consumes a couple of hours in reading a question embodying all the testimony favorable to the defense and omitting everything else. The answer of the experts to such a question is, naturally, that the defendant is insane. The prosecution presents its side of the testimony in a similar hypothetical question embodying the testimony for the prosecution and, obviously, the answer is that the defendant is sane. The experts are made to appear in opposition, whereas neither has had an opportunity to answer a question as to the actual state of the defendant based on the evidence and personal examination. Fortunately, as Doctor Cushman points out, reasonable judges are now utilizing the reports of competent nonpartisan experts. The recent power of the judge to comment on the evidence gives him the opportunity to tell the jury the truth about the hypothetical question.

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Milton B. Lennon, M.D. (384 Post Street, San Francisco).—Doctor Cushman's wide experience with the problems of the so-called "criminal insane" gives him the halo of some authority.

We who have had but a minor experience have a sense of overwhelming insufficiency when we view the problem. Its facets are many. The legal side is mixed up with the medical aspects, and yet a certain deal of common sense should help to solve the question. The rights of the individual and of the public must be conserved.

A man is indicted as the perpetrator of a crime. The judge may recognize the fact that he has a psychosis, appoint a psychiatric board, have an investigation, and immediately commit him to a state hospital.

Another indicted individual may make a twofold plea: First, "Not guilty," and second, "Not guilty by reason of insanity." He and his lawyers have a dual purpose. If he is found guilty a second trial on the insanity plea is made, with the hope that the jury will find a verdict of insanity, and that, instead of a long sentence in prison, he will be sent to a state hospital. At the end of a year he can start proceedings to be discharged from the state hospital. Remember, that a lay jury has brought in the verdict of insanity, and that at times this is done in the face of unanimous medical testimony to the contrary. Careful study during the year's stay at the hospital may fail to disclose any psychosis, and hence the superintendent has no alternative than to discharge the patient.

Again a man may be adjudged insane by the jury, and this time in conformity with the medical evidence. At the hospital careful study by the superintendent and his staff may lend further evidence of a psychosis. Even such an individual may, at the end of a year, bring legal action and attempt to be discharged. What is more, men have succeeded in regaining their freedom despite the protests of the hospital superintendent. Now such things do not happen often, but they never should happen.

There should be no double plea, and if there is the usual second part should take precedence over the first. If the plea is made of "Not guilty by reason of insanity," I am in hearty accord with Doctor Cushman's valuable suggestion. An intensive psychiatric study of the individual should be made. In some instances a conclusion can be quickly reached, in others only a time-consuming investigation will lead to a logical diagnosis. Hence, the period of stay at a hospital should be left entirely to the discretion of the superintendent. In this way no psychotic patient will find himself in jail. The malingerer will be ferreted out by observing eyes.

We of the medical profession should use every means to bring about legislative action that will further Doctor Cushman's proposal.

Equally important, in my opinion, is a change in the law that permits a patient to take legal steps toward his discharge at the end of a year. A longer period, say of five years, should be substituted before such an action is permitted. The matter should be far more a medical than a legal question. A proviso might be made that, after a year and at the discretion of the superintendent, a patient may be discharged if the psychosis is cured, and no superintendent would hold a patient if such were the case.

COCCIDIOIDES IMMITIS INTRADERMAL SKIN REACTION*

A PRELIMINARY REPORT OF 449 CASES

By Samuel Hurwitz, M.D.
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and
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THE purpose of this paper is to evaluate the coccidioides skin test as a diagnostic measure. To our knowledge there has been no previous similar report in the literature. Jacobson,[1] using a filtrate of a coccidioides growth on Sabouraud's bouillon, tested six noninfected persons and obtained negative results except in one case of blastomycosis. A positive reaction resulted in six patients with coccidioidal granuloma. He stated that coccidioides immitis produces a filterable substance

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Note.—Since this paper was submitted for publication we have encountered a case of coccidioides of the lung in a white male, proved by biopsy, which gave a negative skin reaction.

which gives a characteristic skin test on patients with coccidioidal granuloma, as does tuberculin on patients with tuberculosis. Cooke[2] using (*a*) a filtrate, (*b*) an emulsion of mycelia, and (*c*) a suspension of spores, both intradermally and by the Von Pirquet method, obtained positive results on a case of coccidioidal disease and six controls. He concluded that there is no specific skin reaction in coccidioidal granuloma. Hirsch and Benson,[3] on the other hand, concur with Jacobson[1] that coccidioides immitis, cultured in liquid media, produces a soluble specific substance that yields a cutaneous reaction in infected persons. Furthermore, Hirsch and D'Andrea[4] found that guinea pigs could be sensitized with broth culture filtrates of coccidioides immitis and killed dried mycelia. Positive skin reactions were obtained with different strains of the mold, thus showing that there is no specificity of strain. The testes of sensitized animals produced acute inflammatory exudates in the presence of antigen, so that these observers believed the skin reaction to be on an allergic basis probably.

METHOD

The material used in this study was prepared in the following manner. An old broth culture (1925) of coccidioides immitis, mycelia and spores, isolated from a patient with the disease, was heat-killed, dried and suspended in normal saline. Phenol was added as a preservative. The material was standardized so that each cubic centimeter of solution contained 0.1 milligram of the culture.

One-tenth of a cubic centimeter of the above material is injected intradermally on the flexor surface of the forearm, and the reaction is read in twenty-four, and again in forty-eight hours. Normal saline is used as a control. A positive reaction consists of an area of induration 5 millimeters or more in diameter about the site of injection at the end of the forty-eight-hour period.

DISCUSSION

This series comprises 449 tests done on patients ranging in age from ten months to eighty-five years, and hospitalized in San Francisco, San Joaquin, Kern, and Fresno counties. In this group there were twelve cases of coccidioidal granuloma, 177 tuberculous infections, and 260 miscellaneous diseases. The coccidioides cases cited above were proved either by identification of the organism from the lesions or by autopsy. Table 1 lists the incidence of positive skin reactions in various conditions.

TABLE 1.—*Incidence of Positive Coccidioides Skin Test*

Classification	Total Number of Cases	Number Positive	Per Cent Positive
Coccidioides	12	12	100.0
Tuberculosis	177	49	27.5
Other diseases	260	11	4.2
Total	449	72	16.0

TABLE 2.—*Coccidioidin Reactions in San Joaquin Valley and Other Areas*

Location	Total Number of Cases	Number Positive	Per Cent Positive
San Joaquin Valley	184	37	21.0
Other areas	253	24	9.5

The coccidioides intradermal skin reaction was positive in all twelve patients with proved coccidioidal granuloma. Previously, Miller[5] had pointed out that a positive skin test is invariably obtained in patients with the disease.

A striking feature of our results is the high incidence of positive reactions in tuberculosis. Beck, Traum, and Harrington[6] have called attention to the close relationship between the tuberculin and coccidioidin tests in animals. They observed positive tuberculin reactions in guinea pigs injected with coccidioides immitis. Further investigation of the interrelationship of these two diseases should be attempted.

Occasional positive skin tests (4.2 per cent) were obtained in a group of 260 patients with miscellaneous diseases other than tuberculosis or coccidioides. It may be that a diminution in concentration of the material employed will reduce or eliminate false positive reactions. Further study along such lines is contemplated.

San Joaquin Valley is regarded as an endemic area of coccidoidal granuloma, and a comparison of the results of intradermal skin tests in this region with the other areas is shown in Table 2.

In 184 patients without a previous history or evidence of a coccidioidal infection, resident in the San Joaquin Valley, there were 37 (21 per cent) positive reactors, while in a group of 253 cases living in other regions of the State only 24 (9.5 per cent) were positive. The incidence of tuberculous infection was approximately the same in both series. These results are interesting in view of the fact that it has been suggested[5] that perhaps in endemic areas some inherited resistance may be built up through many generations, or some people may acquire coccidioidal granuloma in a mild form from which they recover and develop a resistance. However, the mechanism of immunity in coccidioidal granuloma remains still unsolved.

SUMMARY

Intradermal skin tests with killed coccidioides organisms were carried out on 449 hospitalized patients. All twelve patients with proved coccidioidal granuloma reacted positively. Positive reactions were obtained in other conditions, particularly tuberculosis. A higher incidence of positive reactors was found in noninfected residents of the San Joaquin Valley, an endemic area, than elsewhere in the State.

University of California Medical School.

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PHASES OF ADOLESCENT DEVELOPMENT IN GIRLS*

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Berkeley

Discussion *by H. Lisser, M. D., San Francisco; William Anthony Reilly, M. D., San Francisco; H. E. Thelander, M. D., San Francisco.*

THE present report is concerned with the significance of individual differences in body build as a factor in growth and development. Physical, physiological, and observational records of a group of about one hundred girls furnish the basis for the study. The physical data include anthropometric measurements, clinical physical examinations, observations, x-rays, and serial photographs. The children studied here, as a part of the seven-year study of adolescence being carried on at the Institute of Child Welfare, have been examined each six months, beginning at the age of approximately ten years.

The longitudinal method has been used, the development of each child being followed over a period of several years. This has required the maintenance of cumulative records, and makes possible both the consideration of status at successive age levels, and of cross-sectional as well as longitudinal relationships. Interrelationships between several of the different types of data have been traced.

As a technique for exploration of relationships, a group of girls of extremely slender build have been contrasted with another group of girls characterized by extremely broad body build. These two samplings at the extremes of the normal distribution were selected [1] on the basis of an index of body build, consisting of bi-iliac diameter divided by standing height. Data from the two contrasted groups reveal certain significant relationships between the anatomic measures and physiological variables. The two groups of children have characteristically different growth patterns. The findings suggest that, in studies dealing with growth and development, proper interpretation of the data from a random sample requires the recognition and measurement of individual differences, and proper allowance for certain individual patterns of growth.

* From Stanford University and Institute of Child Welfare, University of California.
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THE ASSESSMENT OF GROWTH

In the measurement of growth, it is necessary to recognize a number of variables in addition to actual stature or size. The important thing in growth is the maintenance of an adequate rate of progress, normal for the individual, rather than the attainment of uniform size for all individuals at a given age. It is necessary to recognize big-boned family lines and small-boned family lines, as well as the stunting effects of certain serious illnesses. In the present study, interviews with the parents were held in order to gather information on family heredity, as a help in recognizing growth patterns.

The use of x-rays in study of physical growth is comparatively recent, but various methods of measuring the extent of ossification have been devised in order to assess development.[2-4] Appearance of centers of ossification, stages of fusion of epiphyses with their diaphyses, total carpal area, and diameters of the carpus have all been used by various authors to estimate anatomic age. Todd [5,6] used centers of ossification in shoulder, knee, and foot, to supplement hand and wrist in order to judge skeletal development. Both Rotch [7] and Stevenson [8] have demonstrated the wrist to be an adequate indicator of the ossification in all the epiphyses in the skeleton. Since this area can be x-rayed with the least expense or inconvenience of any part of the body, it is the one now generally used. The wrist is a satisfactory area in which to study ossification, because, while cartilaginous at birth, it has eight bones at maturity, and hence in the transition it exhibits many stages of development.

Centers of ossification appear in definite sequence, and failure to appear when they should indicates an illness at or near the time of appearance. The ends of the long bones, particularly the tibia, and the radius, are marked with rings which show pauses in the bone growth following severe measles, scarlet fever, or other long-continued fever. Children from slum districts show more developmental scars of this type than do those in better homes.

The various retardations in development due to illness may be responsible for some of the irregularities in growth noted during the adolescent period. These irregularities are no doubt related to the awkward phases of imbalance between bone growth, muscle growth, and endocrine or organ maturity. The awkward stage of stress and strain is more marked in early adolescence, and disappears as irregularities in growth diminish.

X-rays show no distinction in amount of ossification in boys and girls up to five years. By age ten, the girls show quite a developmental spurt, and the girls finally attain their mature form before boys. The female skeleton reaches approximately its adult level at about fifteen years, when the epiphyses close and there is no further growth in stature. In boys, adult stature and skeletal weight are not attained until age eighteen.

We have used the appearance and growth of centers of ossification in bones, to measure physical

TABLE 1.—*Means and Standard Deviations of Distributions of Anthropometric Measurements of Ninety-three Twelve-Year-Old Girls*

	Mean	Standard Deviations
Chronological age (years)	12.2	.13
Weight (in kilograms)	43.0	84.4
Height*	1,509.1	70.3
Sitting height	787.4	37.5
Stem length	772.8	38.5
Bi-acromial diameter	322.5	18.0
Bi-iliac diameter	244.5	16.5
Bitrochanteric diameter	278.3	22.2
Chest breadth	234.6	16.9
Chest depth	158.7	16.4
Neck circumference	289.2	15.8
Chest circumference at nipple	755.3	73.0
Chest circumference submammary	698.5	55.2
Arm circumference	219.0	22.0
Thigh circumference	457.7	51.6
Leg circumference	307.0	23.9
Breadth and length	162.3	7.8
Per cent breadth and length	.33	4.7

* Measures 3 to 16, inclusive, are recorded in millimeters.

TABLE 2.—*Anthropometric Measurements of Nine Girls, Classified as Linear*, Measured at Ages Between 12 and 12.4 Years*

Variable	Mean	Range of Scores	
		Highest	Lowest
Chronological age	12.1	12.4	12
Weight	36.2	45.3	25.3
Height	1,493.5	1,617	1,389
Sitting height	763.5	839	704
Stem length	752.4	815	698
Bi-acromial diameter	313.3	338	281
Bi-iliac diameter	221.1	249	196
Bitrochanter	256.3	289	231
Chest breadth	215.5	233	200
Chest depth	152	172	134
Neck circumference	273	293	250
Chest circumference at nipple	681.8	720	590
Chest circumference submammary	648.5	680	582
Arm circumference	199.7	232	165
Thigh circumference	399.6	487	243
Leg circumference	288.2	314	246
Breadth and length	148.3	155	141
Per cent breadth and length	– 7.5	– 12.2	– 4.3

* Girls who were 1½ standard deviations narrower than the average were classified as belonging in the extreme "Linear" group. These data are to be compared with Table 3, which gives similar measurements for the nine girls classified as "Lateral."
Body weight is recorded in kilograms; other anthropometric measurements are recorded in millimeters.

development, following the technique described by Dr. T. Wingate Todd, who has studied the problem extensively over a period of years.

In this series of data, a skeletal age difference of three and one-half years is the maximal difference between the most accelerated and the most retarded bone-ages at a given chronological age. This indicates the great extent of individual differences in skeletal development at a given chronological age. A child whose skeletal ossification exceeded or lagged behind the mean of her age-sex group by more than nine months (three times the standard deviation) was classed as of accelerated or retarded development, respectively. Children were classified as average, who did not exhibit as much as nine months' acceleration or retardation.

THE MEASUREMENT OF BODY BUILD

As a part of the measurement procedure every six months, a series of anthropometric measurements was taken. (See Table 1). These included measures of both length and width, and provided the basic data for determination of body build, the

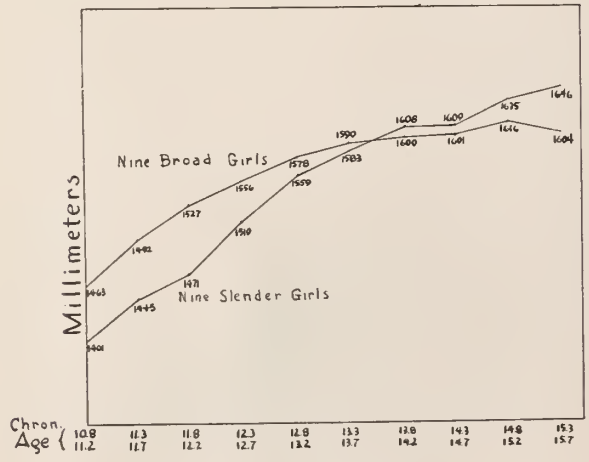


Chart 1.—Growth curves height.

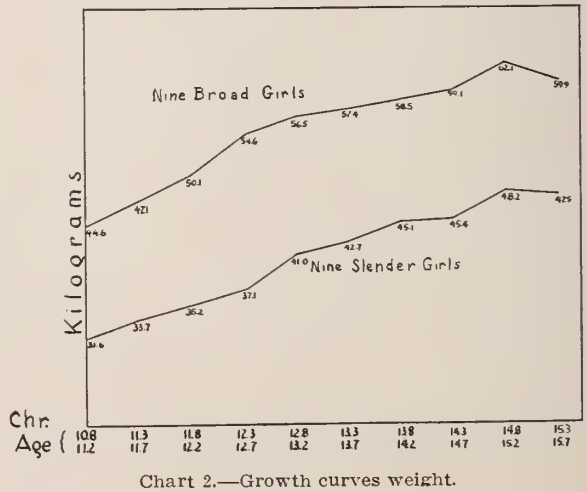


Chart 2.—Growth curves weight.

TABLE 3.—*Anthropometric Measurements of Nine Girls, Classified as Lateral*, Measured at Ages Between 11.9 and 12.4 Years*

Variable	Mean	Range of Scores	
		Highest	Lowest
Chronological age	12.2	12.4	11.9
Weight (kilograms)	51.8	63	42.3
Height (millimeters)	1,537.1	1,634	1,435
Sitting height	807.8	864	750
Stem length	792.7	850	719
Bi-acromial diameter	335.1	370	304
Bi-iliac diameter	266.7	280	252
Bitrochanter	298.8	318	264
Chest breadth	254.3	280	232
Chest depth	167.5	216	140
Neck circumference	305.6	332	288
Chest circumference at nipple	829.3	966	746
Chest circumference submammary	756	910	698
Arm circumference	241.7	269	208
Thigh circumference	506.7	566	455
Leg circumference	330.3	360	300
Breadth and length	173.6	181	165
Per cent breadth and length	7.4	11.6	4.3

* Girls who were 1½ standard deviations broader than average were classified as belonging in the extreme "Lateral" group. These data are to be compared with Table 2, which gives similar measurements for the nine girls classified as "Linear."

Body weight is recorded in kilograms; other measurements are recorded in millimeters.

Table 4.—Results of X-Ray Assessments of Growth of Skeleton, for Slender and Broad-Built Girls

A. Linear (Slender) Group

Case	Chronological Age	Hand* Assessment	Age Equivalent	Age Ratio
127	14.6	21	13.25	90.7
125	14.2	20	12.75	89.8
43	14.4	22	13.75	95.5
113	13.9	22	13.75	98.9
299	13	20	12.75	98.1
39	15.5	25	15.25	98.4
133	14.1	22	13.75	97.5
159	14.4	23	14.25	98.9
19	14.1	22	13.75	97.5
Average	14.2	21	13.25	96.1

B. Lateral (Broad-Built) Group

Case	Chronological Age	Hand* Assessment	Age Equivalent	Age Ratio
15	14.6	26	15.75	107
297	13.1	22	13.75	105
141	14.6	27	16.25	111
1	14.1	26	15.75	112
207	14.6	24	14.75	101
227	14.3	27	16.25	113
205	14.0	25	15.25	108
233	14.0	26	15.75	112
135	14.5	27	16.25	112
Average	14.2	25.5	15.53	109

C. Intermediate Group

	Averages for Ninety-three Girls
Chronological age	14.5
Wrist assessment	23.8
Age equivalent	14.5
Age ratio	100

* The x-ray assessments were made by Dr. Nancy Bayley.

computation of a convenient index of body build, and the selection of groups of individuals to exemplify the extremes of the distribution.

The normal sampling of girls at a given chronological age (*e. g.*, twelve years) shows a wide range of variation in each of the measures used. We have been especially interested in subsamples, selected from the extremes of the distribution with respect to body build. A classification into lateral (broad-built) or linear (slim) groups, based entirely on width-length indices,[9] has been used in selecting the subsamples. The measure employed is bi-iliac diameter divided by standing height. Girls who varied as much as 1.5 standard deviations from the mean in either direction were included in the extreme groups, used for a number of preliminary investigations.

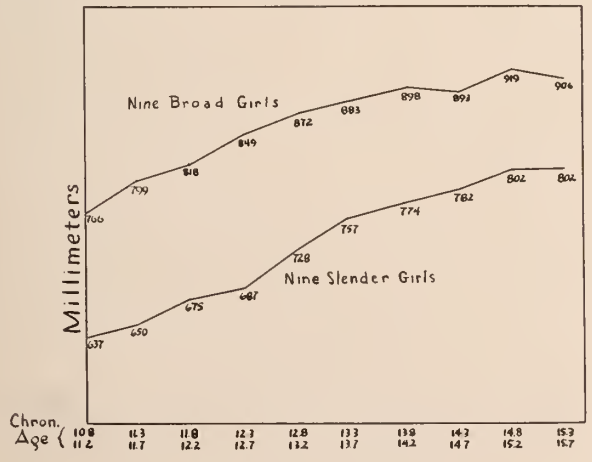


Chart 3.—Growth curves chest girth.

In Table 1 are given the means and standard deviations of anthropometric measurements of ninety-three twelve-year-old girls. These data are used as a general basis for comparison. Tables 2 and 3 show the same measurements for the linear-type and lateral-type girls, respectively, in the same series, and hence the three tables record the extent of variation in the normal sample, and the nature of the groups used to illustrate the extreme variates. Charts 1, 2, 3, and 4 are graphic representations of differences in body measurements between

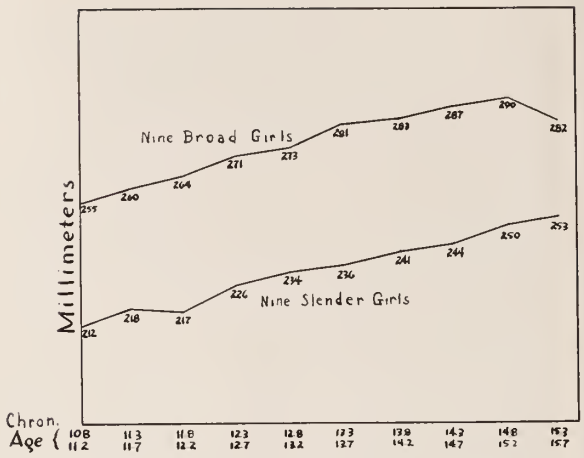


Chart 4.—Growth curves bi-iliac diameter.

linear and lateral groups of girls for a period of four years.

Using this lateral-linear classification, based entirely on width-length indices,[9] it is interesting to note that fifteen anthropometric measurements fall in line consistently year after year, with almost no overlapping. This is an indication of harmony and consistency, which supports the hypothesis that the two selected extreme groups differ in total body-build pattern, and not merely in one or two dimensions.

CLINICAL MEDICAL EXAMINATIONS

At the time of the regular physical examinations, observations were made of general health conditions, colds and other infections, posture, strength, muscular tone, and nutritional status. In addition, records were kept of handedness, eyedness, scapular type, and other conditions relating to development, coördination, and general health. Ratings were made of developmental conditions diagnostic of maturation, such as presence and amount of axillary and pubic hair, development of breasts and of subcutaneous tissue in other areas, and the time of establishment of catamenia. Photographs taken at these regular intervals furnish a permanent record of many of these facts, and of additional configurational factors difficult to describe other than by photographs.

Figures 2 and 3 are outline drawings of a linear type and a lateral type girl, respectively, showing the same girl at successive six-month intervals in each case. These figures portray aspects of growth characteristic of persons in the two classifications. Tracings were made of standardized photographs, to obtain the outlines, and the meanings of the various labels are as follows:

1. Height deviation range—percentage above or below average.
2. W/H index range—percentage broader or narrower than average.
3. Scapular type—CC (concave), CV (convex), and St. (straight).
4. Handedness—right or left.
5. Eyedness—right or left.
6. BMR range—highest to lowest.
7. Joint maturity x-ray—appraisal of ossification of the hand.

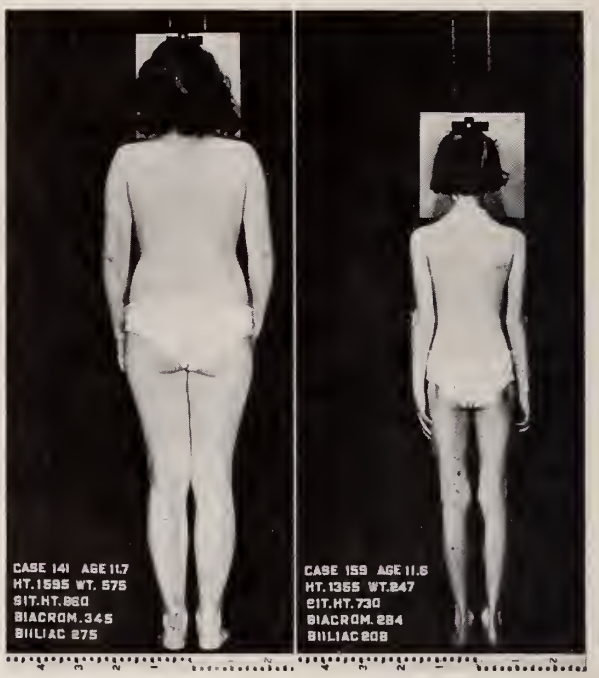


Figure 1.

Axillary and pubic hair, and size of breasts were rated as previously described.[1] The time of establishment of catamenia is indicated by a star on the figure. The five outline columns represent percentage increase over previous six months in bi-acromial diameter, bi-iliac diameter, height, stem length, and girth of calf, respectively.

The average age of appearance of catamenia in the broad-built group was 11.7 years, while the average age in the slender-built group will be over fourteen years. The exact average for this latter group cannot be calculated at present, because some of them have not yet menstruated.

There was very little growth in height in the broad-built girls after appearance of catamenia, while growth in height increased regularly in the slender girls of the same chronological age. Growth in diameters and girths slows up markedly in the broad-built girls during the same period of time that the slender girls start their adolescent spurt in growth.

Study of the results of these clinical medical examinations shows that some of the great variation in human growth at puberty is due to the mixture of the different types, one of which grows rapidly at age eleven to twelve years, and reaches full stature. The other type begins the adolescent spurt one to two years later, grows more slowly, and matures later.

In the present-day enthusiasm for establishing standards of growth and development, and for regimenting school children, the importance of individual differences is often overlooked, or inadequately considered. The general attitude that all persons are to be evaluated by reference to the same standards, when applied to physical and medical data, works an injustice on those individuals who vary from the average to a marked degree. In many individuals, growth follows a course quite

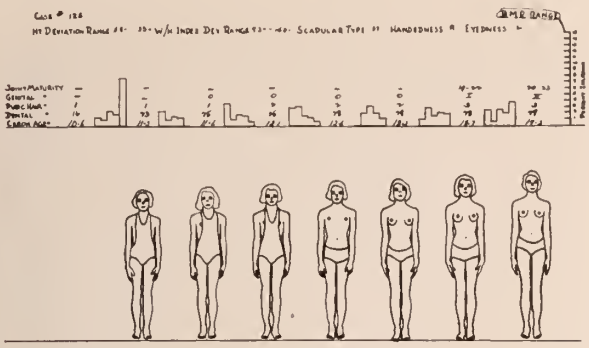


Figure 2.

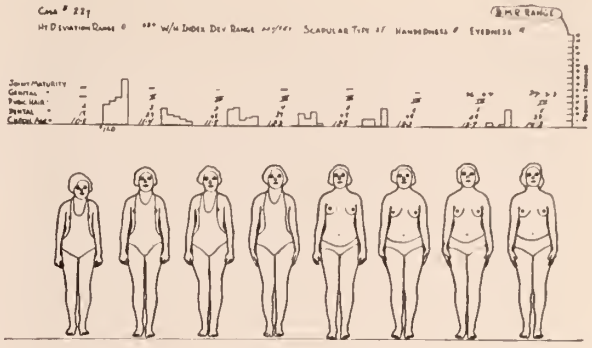


Figure 3.

unlike that of the average person, but entirely normal for the individuals concerned.

INTERRELATIONSHIPS

Figure 1 shows standardized photographs of a linear and a lateral girl, matched for chronological age. The slender-built girl lagged behind the broad-built one in ossification two and one-half years, and in establishment of catamenia four years. These photographs illustrate the sort of developmental difference associated with difference in body build.

Table 4 shows chronological age, assessment of bone development, age equivalent, and age ratio, for all of the very broad and very slender girls in this series, compared with the averages for the whole series. All of the lateral group of girls had accelerated bone development, and all of the linear group had retarded bone development.

Hence, in addition to individual divergencies from average, which might be due to acute diseases, there appears to be a body-build difference in ossification. The x-ray studies of our adolescent group show that ossification proceeded more rapidly in the broad-built than in the slender-built. In the latter group, epiphyseal ossification consistently lagged behind that in the broad-built group. The evidence for the two groups is shown in Table 4; the picture is consistently similar to that of the cases used in the illustrations of Figure 1.

SUMMARY AND CONCLUSIONS

As part of the larger study of adolescence being carried on at the Institute of Child Welfare, a longitudinal study of physical and physiological aspects of growth and development of one hundred girls has been included. Retests at six-month periods over a period of several years have included anthropometric measurements, clinical physical examinations, observations, x-rays, and the taking of serial photographs. The analysis of the cumulative records justifies the following conclusions:

1. Individual differences must be recognized in the assessment of growth. The important thing is the maintenance of an adequate rate of progress, and not the attainment of an absolute stature or size.

2. When body build was classified entirely on the basis of width-length index, study of extreme groups revealed interesting consistencies in other measurements, in relation to body build. In each of fifteen anthropometric measurements, wide differences were observed between broad and slender girls, with no overlapping at any point.

3. Study of the records indicates that physiologic development parallels rather closely anatomic development. Marked differences in rate of maturation were observed, as the broad-built girls matured at an earlier age than did the slender girls.

4. When x-ray methods were used to assess development by estimating anatomic age, a body-build difference in time and rate of ossification was demonstrated. On the wrist assessments of anatomical age from x-rays, broad-built girls had age equivalents greater than their chronological ages, and slender-built girls had age equivalents less than their chronological ages. The age ratios, when averaged, were 109 for the broad-built and 96.1 for the slender-built girls.

5. The data led to the conclusion that the mixture of groups of individuals heterogeneous with respect to body build accounts for some of the great variation in human growth at puberty, when observed in any ordinary unselected sampling.

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DISCUSSION

H. Lisser, M. D. (384 Post Street, San Francisco).—This study distinguishes, with great clarity, two widely different types of skeletal growth in *normal* adolescent girls—the "lateral" or broad-built group and the "linear" or

slim-slender group. Merely calling attention to broad and slender skeletal patterns would elicit little interest if it were not for the fairly consistent, associated distinctions involving the degree of osseous development or "bone-age" and the concomitant sexual age. These latter findings are of trenchant significance, for they emphasize, even in *normal* girls, the intimate inter-relationship between sexual maturity and termination of growth. Thus, if the menarche occurs for instance at twelve years of age, the "bone-age" will probably be nearer fifteen years, and longitudinal growth will practically cease when this girl reaches the age of fourteen. This study points out that this combination of events is most frequent in the broad-built type of girl who matures relatively early and, therefore, stops growing comparatively early. Contrariwise, the slender-type girl matures later, at fourteen or fifteen years of age; her "bone-age" is apt to be slightly retarded in comparison to her chronological age, and the onset of menstruation and fruition of secondary sex characteristics will be correspondingly delayed. Yet, both these extremes are fairly common and within reasonable limits may be considered normal.

The recognition of these two divergent types in *normal* girls, with accompanying differences in osseous and sexual development, leads to a consideration of these two types when exaggerated to a degree interpreted as *abnormal* or pathological. In addition to normally inherited, constitutional factors influencing skeletal patterns, attention must be paid to the dominating rôle of the endocrines in controlling growth and sexual development. Thus, a granulosa-cell tumor of an ovary producing precocious sexual maturity, with onset of menstruation during the first few years of life, will stimulate rapid skeletal growth at first, but with advanced ossification and premature closure of the epiphyses resulting in early cessation of growth. Similarly, an adrenal cortical tumor originating in a little girl causes a pseudo-sexual precocity, with early appearance of pubic hair, enlarged clitoris, accelerated skeletal growth and again advanced "bone-age" with eventual shortness. The skeletal set-up of such girls is apt to be "lateral," broad-built, or heavy, a pathological exaggeration of what the authors described in normal adolescent girls. Such girls at a chronological age of five years, may have a "bone-age" of twelve.

On the other hand, the antithesis of such precocious ripening is exemplified in preadolescent eunuchoidism, the clinical picture of which is typified by eunuchoid-tallness (not true gigantism), with disproportionally long extremities, slenderness, severe delay in appearance of secondary sex characteristics, very late onset of menstruation, if at all, and in unison, extreme retardation of ossification. This type of endocrinopathy would be illustrated by a girl of twenty-four years, with no mammary development, with very sparse pubic hair, who has not menstruated, with span greater than height and lower measurement far exceeding the upper, and with an osseous status of twelve years.

In the previous two paragraphs endocrinopathies have been described which illustrate extreme exaggeration of the two normal types defined by Drs. Pryor and Carter. The discussant has studied a considerable number of such patients, but so severe disturbances of endocrine function are uncommon. Manifestly, however, instances of milder deviation, between the extremes of normal and grossly abnormal, are to be expected, and are encountered quite frequently. Proper recognition and appropriate therapy can be extremely helpful.

It is to be emphasized, therefore, that the authors' careful observations in normal adolescent girls corroborate the important corelations, long known to endocrinologists in more outspoken form, between skeletal patterns, "bone-age," and the degree of sexual maturity. Broad-built girls mature early, and grow very little after thirteen years of age, whereas linear slender girls mature relatively late and, therefore, are still growing at sixteen. "Bone-age" estimations should be utilized more frequently in pediatric practice. The thyroid, pituitary, adrenals, and gonads have important influences in accelerating, delaying, or arresting both skeletal growth and sexual maturity.

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William Anthony Reilly, M. D. (384 Post Street, San Francisco).—From Doctor Pryor's significant and interesting findings practitioners should recognize several helpful trends. These are: That there are individual differences in body-build (linear, lateral, and mixed); that it is incorrect to consider only a mean or an average for the growth factor of height, weight, epiphyseal age, pulse, blood pressure, basal metabolism rates, etc.—in place of means or averages we should always consider the limits of the range of findings; that there is a difference between chronological age and physiologic or anatomic age—the latter including maturity, bone-age, etc. Such proven facts help the practitioner allay the fears of family, teacher, and school nurse, concerning normal weight and the like. If one takes into consideration skeletal build (and especially the height-width index), the child very often is quite normal in weight.

I believe pediatricians, especially, are making more use of these findings. It will be practically helpful to practitioners when standards for basal metabolism can be computed on body-build better than at present.

Of personal interest to me is the finding that broad-built girls often have the following findings—they are mostly of European stock, with marked acceleration of bone-age, tall and obese, and some years premature physical and gonadal maturity. They have a definite tendency to a lowered basal metabolism. Physical measurements, examination of the genitalia, and glucose tolerance tests were uninformative. Tests for growth and sex hormones gave negative results. I have never been able to ascribe a definite physiological reason for these findings.

❦

H. E. Thelander, M. D. (384 Post Street, San Francisco).—The recent tendency to study intensively the individual and his variation from the mean cannot be too highly commended. Problems arise in individuals and not in masses, and it is usually the extreme deviate who becomes a problem. Adolescence represents an age in which variations are most marked. A study like this will eventually be of great service, not only to the medical man but to the psychiatrist and the educator—in fact, to anyone dealing with children in this age group.

ROENTGEN THERAPY: SOME OF ITS COMPLICATIONS*

By Richard T. Taylor, M.D.
Los Angeles

Discussion *by L. H. Garland, M. D., San Francisco; John D. Lawson, M. D., Sacramento; Wilbur Bailey, M. D., Los Angeles.*

IN this day of large roentgen dosages when the cry is on to more and bigger voltages, to more and more milliamperes and to more and huger roentgens, very little is said regarding the *bad* effects of increasing doses; and yet we all see them and fear them. Believing that a review of what one can see and feel in the patient undergoing treatment is a better exposition of our difficulties, especially if one uses the words of a master therapist, than a discussion of microscopic data, I beg leave to outline some points from Doctor Coutard's talk in Chicago last winter, wherein this subject received the best treatment I have ever heard.

MUCOUS MEMBRANES

If we have an individual who presents a cancer of the pharynx and we apply irradiation every day through two opposing fields, each about sixty square centimeters in size, for a dose of 4000 r in ten days, and if we examine the patient each day, we see on the irradiated mucous membrane a complete destruction of all epithelial cells, leaving the

* Read before the Radiology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

denuded dermis, which is covered immediately by a false membrane composed of fibrin and avirulent microörganisms. This reaction or radio-epithelite reaches its maximum on the thirteenth or fourteenth day and is generally repaired after five, six, or ten days, depending upon the patient. This same irradiation produces also destruction of the epithelium of the skin, but the destruction of the skin reaches its height on the twenty-sixth to the twenty-eighth day, and is generally repaired after ten to fourteen days.

If, instead of irradiating the respective tissues in ten days, the irradiation is extended over a longer period—eighteen days—one observes that the radio-epithelite occurs at the same time, that is on the thirteenth day, but with a weaker intensity, and that the same is true for the skin. If now we perform the irradiation over a still longer time—say, forty-five days—yet, using the same total dose, we see an incomplete or partial radio-epithelite appearing on the mucous membrane every thirteenth day—that is, on the thirteenth, twenty-sixth, thirty-ninth, and fifty-second days. Therefore, these periods constitute the moments of radiosensitivity of the mucous membrane or, in other words, its radiosensitivity is periodic. Coutard was the first to observe this.

If the daily dose be greatly increased, it frequently happens that the radio-epithelite is absent or occurs only partially, or that it is replaced by an intense lesion of the connective and vascular tissues, or that it occurs beyond the normal time of thirteen days; say, on the twenty-first day. Under these circumstances, the radio-epithelite is accompanied by very painful symptoms, and the membranes are thick and not thin and confluent, or they may be necrotic and repair very slowly.

CARCINOMA

Summarizing, we observe that there is an *upper* threshold, above which the radio-epithelite is delayed, painful, abnormal, incomplete, partly replaced by an intense lesion of the chorion and below which the radio-epithelite is total and normal. regarding time and intensity; a *medium* threshold above, which it is normal regarding time and intensity, and below which it is incomplete and periodic, and a *lower* threshold, below which there is no visible radio-epithelite. Since the effects of irradiation on the neoplastic epithelial cells are very similar to the effects on the normal epithelial cells, we see that between these three thresholds the roentgen therapy of cancer has to be applied. The problem is even more complex for depending on whether the mucous membranes have an epithelium, more or less, similar to the skin type—that is, with a tendency to hornification, as on the dorsal part of the tongue, the mucous membranes of the cheek and of the vocal cords, the moments of these radio-epithelites may be found anywhere between the fourteenth and the twenty-eighth days.

CONNECTIVE AND VASCULAR TISSUES

Turning now to the connective and vascular tissues, we come to the subject of edema. This is the chief, clinical reaction to irradiation in these tissues, and it may be early or delayed.

The precocious edemas appear most frequently after the first or second day of irradiation, and they indicate that the daily doses have been somewhat intense. They are usually painful and point to a certain fragility of the connective and vascular tissues. They are seen when the tissues are infected, as in infected lymph nodes. The late edemas appear two months to one year after treatment and may be superficial or deep. The superficial edemas often appear following a common cold or slight infection, and may recur periodically. They usually disappear about the end of the second year. When the edema affects the deep tissues, it generally means profound modification of the blood vessels by irradiation, and points to a daily dose or total dose that was too high or poorly spaced as regards the time factor. If the deep edema persists, it may indicate recurrence. When a persisting edema undergoes periodic regression, the probability is that there is a necrosis of the mucous membrane or cartilage, as in the delayed edema of the epiglottis, terminating in the elimination of a piece of necrotic cartilage. With the elimination of the necrotic part the tissues return to normal. The edemas which appear during the course of treatment constitute an indication which is difficult to interpret. They may be due to excessive or to insufficient doses. For example, in a radiosensitive cancer, edema may appear after the disappearance of a part of the tumor and indicate a too fragile vascular and connective tissue. In the case of a radio-resistant cancer, the edema may be due either to an excessive dose in relation to the connective and vascular tissues or to an insufficient dose in regard to the neoplasm. In the latter case increasing the dose will suffice to clear up the edema by modifying the tumor mass. If this trial is not effective, it is wise to discontinue the treatment and wait until the reaction in the mucous membrane has subsided. Coutard says that he often sees, in the course of daily uninterrupted treatments, the edema diminish during some days, then reappear and diminish again, indicating a periodic tolerance and intolerance of the connective and vascular tissues, and pointing to a faulty chronological distribution of the dose.

Among other symptoms to be classified with edema as warnings are perversion of taste and dryness of the mucous membranes, and, according to whether these three symptoms have been, more or less, marked during the treatments, one finds, eventually, more or less intense late accidents occurring years later, such as loosening of the teeth, elimination of the teeth or decalcification of the same. Successful treatment depends on keeping the connective and vascular tissues in a relatively normal state during the irradiation. Intense infection of these tissues preceding irradiation, of course, alters the outcome, as in tuberculous infection of the larynx. In treating cancer of the larynx under these conditions, the edema and mucous membrane reactions are more precocious and prolonged than in other patients, and great care must be used.

NEOPLASTIC TISSUES

The observations noted above regarding periodicity in the sensitivity of the mucous membranes, and of the vascular and connective tissues, apply also to neoplastic tissues. If one has to deal with a very embryonal, highly radiosensitive tumor, one is apt to see, as soon as the fifth or sixth day, the cancer covered with a pseudomembrane, and in these cases one expects good results with a protracted program of daily doses. If, however, these pseudomembranes do not appear before the eleventh or twelfth day, one should consider the tumor of much lower sensitivity, and in those cases where the neoplastic radio-epithelite does not appear until after the radio-epithelite of the mucous membrane as on the twenty-fifth day, one can assume a high resistance in this neoplasm. In such a case it is necessary to apply very high daily doses in order to reach the threshold of destruction of the neoplasm, but such high doses must be distributed only by series and at certain moments.

According to Coutard's experience, the time to apply these high daily doses is at the times of increased radiosensitivity of the mucous membrane and connective tissues which are, as we saw above, around the thirteenth, twenty-sixth, thirty-ninth, and fifty-second days. Treatments administered in between these periods, as for example, on the ninth to the twelfth days, the seventeenth to the twenty-second, and the thirty-first to the thirty-eighth, are apt to be followed by edemas unless the daily dose is kept low, too low, that is, to affect a highly differentiated, radio-resistant tumor. These periods can only be ignored, then, in cases of very sensitive embryonal types of tumors.

IN CONCLUSION

In conclusion, may I express my humble opinion that it will be by paying more attention to frequent examinations of the irradiated patient, by more consideration of the distribution of our doses in time in relation to sensitivity and resistance of tumors, and by keeping our fields small, our filters high, and our minute r outputs fairly low, that we will be able to minimize the complications inherent in roentgen therapy.

1212 Shatto Street.

DISCUSSION

L. H. Garland, M. D. (450 Sutter Street, San Francisco).—The complications of roentgen therapy are sometimes serious; the complications of cancer are almost always serious. Many cancers—for example, those of the skin—can be cured with almost no hazard from roentgen therapy; other cancers, such as those of the urinary bladder, can only be cured with significant potential hazard. I am in hearty agreement with some of Doctor Taylor's conclusions and with many of the excellent points which he makes in his text. However, I also wish to disagree with him in respect to some of these points.

I do not believe it has been conclusively shown that the radiosensitivity of the mucous membrane varies in a periodic or wave-like manner. Coutard's observations of marked radio-epithelitis at intervals of thirteen days in patients subjected to protracted, fractionated irradiation, have not been substantiated by other observers. This does not necessarily mean that Coutard is wrong, since the exact reproducibility of a given technique is often difficult, and since patients vary materially in their sensitivity to protracted irradiation. However, before adopting the philosophy of periodicity in the handling of well-differentiated tumors, it will be well for physicians to tread cautiously and be relatively pessimistic.

In the treatment of cancers of the tonsil, pharynx, and larynx, edema is sometimes an annoying complication, but is more often an incidental one, evident chiefly in the submental region and not involving an important portion of the pharynx or larynx. I doubt if it ever is due to "insufficient dose." I admire anyone's courage in increasing the roentgen dose in an attempt to clear up edemas which are regarded as due to an insufficient dose. I cannot regard perversion of taste or dryness of the mucous membrane as an unfavorable prognostic sign. It is almost impossible to treat adequately most squamous-cell carcinomas of the epipharynx and oropharynx, without oral dryness of at least six weeks' duration, and without perversion of taste of from one to three months' duration. The word "dryness" is used by the patient to signify scanty, thick secretion. Perversion of taste is, fortunately, of only transitory significance in most cases. However, I remember two patients who had extensive extrinsic carcinomas of the larynx which were completely arrested by external roentgen irradiation, but who were very unhappy for a period of years owing to marked perversion of taste; one of them complained that everything he ate tasted like "codfish balls."

The complications of roentgen therapy in the handling of cancer are analogous to the complications of surgical therapy. Unpleasant episodes occasionally develop, even in the best hands, and neither method can be conducted by those who are not adequately trained and reasonably experienced in their application. A knife has never cured cancer; a surgical physician has. Similarly, x-rays have never cured cancer; a radiological physician has. Extreme caution in the application of either roentgen or surgical therapy is the best method of preventing complication. Doctor Taylor is to be commended on reminding us of the great importance of using reasonably small fields and adequate filters, and of making daily examination of each and every patient to minimize those complications.

John D. Lawson, M.D. (1306 California State Life Building, Sacramento).—The physician treating malignancy by radiotherapeutic means must consider two phases of therapy: one directed against the tumor and the other toward the patient. We have accomplished no good when a tumor is eradicated, if the patient is dead as the result of too energetic therapy, or confined as an invalid for the remainder of his or her life, through overstressing the destruction of malignant tissue.

Primarily one must estimate just what procedures are necessary to properly cope with the tumor. The type of malignancy, its grade of malignancy, the histologic structure, presence or absence of infection and metastatic manifestations are of paramount importance.

Only recently a patient came into the office detailing that eight years ago a radiotherapist had given him a radium treatment for cancer of the face. Following the treatment there was an intense reaction, with loss of tissue and an area of necrosis which has persisted to date. On examination, it was found that there was a slough the size of a half-dollar in the temporal region, with a large skull defect and necrotic bone projecting into the ulcer. Growing from the meninges and the surrounding skin was a squamous cell carcinoma of a low degree of malignancy, microscopically identical with the original tumor.

In this particular case a low-grade squamous-cell tumor had been treated with intensive dosage of beta and soft gamma rays, with destruction of all tissue except that for which it was applied. Repeated doses of highly filtered radiation, over an extended time, has destroyed all of the recurrent new growth, and a plastic repair can be accomplished in a short time.

It is occurrences like this which cause us to regard every new growth as an individual problem. For the radiologist to say, "I give 1,500 roentgens in all cases of carcinoma of the lip," is absolutely wrong. Unless the patient is studied, unless the tumor is studied, and unless these two are associated and treated simultaneously in an intelligent manner, the good name of radiology will be very sadly besmirched, and cancer treatment by this means will not be accorded the place it so rightfully deserves.

Wilbur Bailey, M.D. (2007 Wilshire Boulevard, Los Angeles).—The author's paper has very properly emphasized the danger of complications, with the present trend toward progressively higher dosages of more penetrating x-rays. With the use of very high voltages in treating cancer of the cervix, for instance, the amount of radiation is limited by the reaction of the pelvic structures themselves under these conditions, rather than the skin reaction as formerly. Postradiation sigmoiditis or proctitis may prove to be complications much more serious than skin damage.

Protracted fractional radiation, as recommended by Coutard, undoubtedly has been a definite advance in radiation therapy. However, the fact that a cancer cell is most vulnerable during its actively growing phase (*i. e.*, during mitosis) still holds. In rapidly growing lymphosarcomas of the tonsil, we have found huge doses given in a few days' time not only theoretically better, but practically resulting in disappearance of lesions which had failed to respond satisfactorily to protracted fractional radiation. Conversely, very slow-growing cancers, such as thyroid metastases in bone, may respond most favorably if treatment is given in short periods every few months over a period of a year or more. Under these conditions the blood supply of the tumor is markedly decreased and its growth is checked, because of the vascular sclerosis caused by repeated doses of radiation.

LOS ANGELES COUNTY HOSPITAL COLLECTION BUREAU*

HOW LOS ANGELES COUNTY CHARGES THE INDIGENT SICK FOR HOSPITALIZATION, WHILE ACCEPTING GRATUITOUS MEDICAL SERVICE TO THE VALUE OF ABOUT TWO MILLION DOLLARS ANNUALLY, FROM ATTENDING PHYSICIANS AND SURGEONS

By George H. Kress, M.D.
Los Angeles

Foreword.—The following exhibits merely scratch the surface of matters discussed and the principles involved. They are given place in this issue to substantiate and amplify the editorial comments on page 73. As there stated, it is of greatest importance to both the citizenry of Los Angeles and California, and the medical profession of the State, that a full investigation of the billing and collection procedures of Los Angeles County be made, to the end that any methods not having warrant in California law, or that indicate a leading to deplorable results, to either public or profession, be carefully reconsidered, that needed changes may be made. It would seem that an impartial investigation, apparently much needed in the premises, might well be made by the Grand Jury of Los Angeles County, which body has both legal authority, and the financial and other means to institute a thorough study of the situation. In the past, each year's Grand Jury has made a report on the county's charitable institutions. Since the last Grand Jury was in session, new problems, as herein outlined, have arisen, and, because of the wide and serious ramifications involved in these more recent methods, a painstaking and intensive survey may well be in order.

The correspondence and other data submitted explain themselves, and, when placed together, should make clear the reasons for such editorial comments as appear in this issue of the Journal. Brief explanatory comments are made in the Exhibits, which follow, these being appended as author's "Comments," each keyed by number into the text. For convenience in perusal, some italics, paragraphs, and florets have been inserted in part of the correspondence. Comment items, with brackets, are by the contributor of this paper.

* This paper was contributed by Dr. George H. Kress, Los Angeles, who has been a member of the attending staff of the Los Angeles County Hospital and of the medical board of its attending staff for more than twenty-five years.

EXHIBIT A

Presents:

1. A letter, dated October 22, 1937, from Dr. George H. Kress to Mr. Everett J. Gray, executive superintendent of the Los Angeles County Hospital, dealing with the new system of billing "all" patients of the Los Angeles County Hospital for hospitalization (not medical) care, and the legal and other background therefor.

2. Superintendent Gray's letter, of a month later, in reply to the above.

* * *

(1. Letter from Doctor Kress to Superintendent Gray)

"Los Angeles, October 22, 1937.

Mr. Everett Gray,
Superintendent, Los Angeles County Hospital,
1200 North State Street,
Los Angeles, California

Dear Mr. Gray:

For some time it has been in my mind to ask you to send me information concerning the amount of moneys collected by the County of Los Angeles from patients who receive medical and surgical care at the Los Angeles County Hospital. [Hospitalization, not professional care.]

It is particularly brought to my mind in the case of the boy Robert Espinoza, concerning whom I wrote today to the Collection Division of the County of Los Angeles, as per enclosed letter.†

I take it that in your own Los Angeles County Hospital office you have records that are easily accessible which show the amount of money annually received from citizens who have been in-patients at the Los Angeles County Hospital. Also the number of citizens who are annually accepted as in-patients, and who do not pay any refunder to the County of Los Angeles. . . . I know you will be glad to send to me the information.

If there are any printed or mimeographed reports that cover this matter I shall appreciate the receipt of the same, and will thank you if you can mark or call my attention to the items that pertain to the subject herein discussed.

This entire matter of refunder to the County of Los Angeles for hospitalization care in the Los Angeles County Hospital is one in which the medical profession is naturally interested. I note in the statement rendered to Mr. Antonio Espinoza that the daily rate which is charged is the sum of $4.32. Kindly write and inform me what is the per capita cost in the care of patients that was listed in the three last annual reports for Los Angeles County Hospital. In other words, does this item of $4.32 per day agree for the current year with the figures which have been previously reported by the Los Angeles County Hospital as

† To conserve space, this letter is not printed.—Editor.

the cost of the care for each patient in that institution?

Have you any additional information that you may be able to send me? It has long been in my mind to discuss this subject editorially in the OFFICIAL JOURNAL of the California Medical Association, and I do not wish to take up the matter until I have at hand as complete data on the subject as it is possible to obtain.

Thanking you for your attention and coöperation in this, and with best personal wishes.

Cordially yours,
GEORGE H. KRESS, M.D."

* * *

(2. Reply of Superintendent Gray to Editor)

"Office of the Superintendent,
Los Angeles County General Hospital
Los Angeles, November 3, 1937.

Dear Doctor Kress:

Subject: 'Hospital Costs and Collections.'

Attached report[1] is sent in compliance with your request of October 22, 1937.

Very truly yours,
EVERETT J. GRAY,
Executive Superintendent."

* * *

[1] Comment.—A better understanding of the "attached report" may be had if Item 8 of the Appellate Court opinion in the Kern County Hospital case, as given on page 108, and the informal opinion of Hartley F. Peart, general counsel of the California Medical Association, on page 109, are first read. Such perusal should indicate at once that somewhere, somehow, the Kern County Appellate Court opinion has been tremendously "stretched."

* * *

(3. Enclosure: "Attached Report")

"The Los Angeles County General Hospital
1200 North State Street, Los Angeles, California
Los Angeles, November 3, 1937.

The amount of money received[2] from citizens who have been inmates of the Los Angeles County General Hospital was, for the fiscal year 1936-1937, $319,741.10, and for the first three months of the fiscal year 1937-1938, $87,741.01. [Ed. note.—For the year, the estimated amount would be $350,964.]

* * *

[2] Comment.—In the last fiscal year ending July 1, 1937, the total "hospitalization income" of the County of Los Angeles from patients who were socially serviced before admission is stated as $319,741.10. The estimated present fiscal year income, based on the first three months, is $350,964, or a probable $31,222.90 in excess of last year. Let it be remembered, however, as stated in the succeeding paragraph of Mr. Gray's letter, that since July 1, 1937, the Social Service Department has ceased to keep records of "free" (presumably indigent?) patients. Why?

* * *

The total number of admissions, exclusive of births, for the fiscal year 1936-1937 was 60,741. Of this number, Social Service records indicate that 38,672 were accepted as "free" patients. The remainder were to pay a part or all of the cost of their care.

Since July 1, 1937, no record of the number of so-called "free" patients has been maintained by Social Service or the Hospital.

All patients[3] discharged from the Hospital since July 1, 1937, *have been billed at County cost in accordance with the requirements of the Kern County Decision,* such patients to pay all or a part of the cost of their care, *if and as they become financially able to do so.*

* * *

[3] Comment.—If we understand this term aright, it means that *every patient,* even though he be absolutely indigent, is billed for hospitalization by the County of Los Angeles! More than that, we have been told that he is made to sign papers, in which, we understand, he practically promises to pay the hospitalization charges in the future; and further, if he has any means at the time, or is liable to have in the future, this indigent citizen, who is so unfortunate as to also be sufficiently sick to need hospital care, must then give the County of Los Angeles a lien on such real or personal possessions or prospective income!

* * *

The responsibility for collection of this legal obligation is that of the Charities' Collection Division.

Social Service investigates the eligibility of patients for care in accordance with the State Public Welfare Act, county ordinances and resolutions of the Board of Supervisors,[4] but does not classify them as to "free," "part" or "full" pay.

* * *

[4] Comment.—To secure copies of the "Public Welfare Act, County Ordinances and Resolutions of the Board of Supervisors" is no easy task. In a proper investigation, these should all be brought out into the light, for study and opinion by competent authorities.

* * *

The collection of moneys for all or any part of care rests with the *Charities' Collection Division subject to legislative regulations.*[5]

* * *

[5] Comment.—What has been stated in Comment No. 4 applies also to "legislative regulations." In due time, it is to be hoped that the County of Los Angeles will be prepared to submit all such legal authority.

* * *

A copy of Board Resolution,[6] *effective July 1, 1937, is attached hereto. The rates set up in this resolution include fixed overhead,* such as depreciation on buildings and equipment, interest on bonded indebtedness, workmen's compensation and other insurance. This resolution is subject to

amendment when so indicated by the institutional cost records.

* * *

[6] Comment.—This "Board Resolution of June 29, 1937" is a very interesting addendum. It is only fair to assume that Mr. E. J. Gray, executive superintendent of the Los Angeles County Hospital, and the medical director, Dr. Phoebus Berman, as the executive heads of the Los Angeles County Hospital, must either have prepared this schedule, in whole or in part, or acquiesced therein, before its submittal and recommendation for passage, to the lay Board of Supervisors.

The ward rates to indigent in-patients of the Los Angeles County Hospital seem to be in excess of the average of those charged in private hospitals in Los Angeles, as witness: California Hospital, $4; Methodist Hospital, $3.75; Cedars of Lebanon Hospital, $4.50.

The County Hospital hospitalization rates for "Special Services" vary greatly from those of private hospitals of the city of Los Angeles. One or two examples of such astounding and excessive variations for "use of operating room" will be given under Exhibit C, on page 105.

* * *

The operating room service unit mentioned in the resolution is the basis for computation of operating room cost. It is comparable to the operating room cost of private hospitals in that *it does not include any amount for the service of the surgeon.* However, the services included and method of computation differ somewhat from those of the private institution.

The Kern County Decision[7] *requires that the charges billed to patients* be according to the type of service received and include a pro rata share of such fixed overhead as depreciation, interest and insurance.

* * *

[7] Comment.—What the "Kern County Decision *requires*" is evidently a matter of opinion. It will be interesting to learn how much of the "capital investment" (land, buildings and equipment) of the Los Angeles County Hospital was brought forward to be used in the computation of the rate schedule. And whether, for instance, in including the new seventeen million dollar acute unit of the institution, such a matter as a "call system" for which the county paid in excess of ninety thousand dollars, but which was never used and later salvaged in being sold for a few thousand dollars, is today included in hospitalization charges against the indigent and near-indigent sick of the county?

* * *

The average over-all cost [for a ward bed, per day] *for the three prior fiscal years*[8] was as follows:

Fiscal year 1934-1935	$4.08
Fiscal year 1935-1936	4.39
Fiscal year 1936-1937	4.42

* * *

[8] Comment.—The average daily charge for a ward bed in one of the private hospitals of Los Angeles that have accredited standing from the Council on Hospitals of the American Medical Association, and from the American College of Surgeons, is about four dollars. In making their charges, these private hospitals must take into account and include items such as the capital investments of their plants, taxes, and depreciation. The Los Angeles County Hospital, with a large number of buildings on a thirty-five acre tract, the Acute Unit Building alone costing seventeen million dollars to erect and equip, may have a total capital investment of, say, twenty-five million dollars, on which, if it were a private hospital, it would be mandatory to pay taxes. Query: Are the interest charges on the twenty-five million dollar capital investment, plus the taxes that would be levied thereon, included in the estimation of the $4.08, $4.09, $4.42 daily ward rates of the last three years? If not, what, then, would the true daily ward rate be? These facts must be kept in mind in comparing costs of equivalent hospitalization service of such a public hospital and private institutions.

* * *

The over-all operating cost listed in the annual reports includes such extraneous services as Ambulance and Mortuary, but does not include depreciation, interest and insurance. In billing under the Kern County Decision, extraneous services are excluded from the basic ward service charge and billed only to those patients who receive them.

Eligibility for admission is determined[9] *by Social Service.* If the patient is financially able to pay anything toward the cost of his care, the ascertainment of such financial ability and future follow-up are responsibilities of the Charities' Collection Division, which undertakes the securing of *reimbursement to the county from recipients of county aid whether the aid given was institutional or direct relief.*

Everett J. Gray,
Executive Superintendent."

* * *

[9] Comment.—The Social Service Department evidently decides who are the "no pay" (indigent) or "part pay" (near-indigent and non-indigent?) patients, to be admitted to the Los Angeles County Hospital. If such is the procedure, the Department of Charities of the county must either have written such rules or acquiesced therein.

Copies of such rules, with dates on which promulgated, and by whom drafted and recommended, are of importance to both the great body of citizenry and the thousands in the medical profession, and should be carefully examined and checked.

* * *

(Copy)

Resolution of Los Angeles County Board of Supervisors of June 29, 1937

"Resolution adopted by the Board of Supervisors, June 29, 1937, covering Schedule of Charges for Care in County Institutions:

In the case of aid granted by institutional care, the reasonable charges therefor, which shall be the measure of reimbursement to the county by indigents and their liable kindred, shall, commencing July 1, 1937, be and the same are hereby fixed as follows, to wit:

In Los Angeles County General Hospital

Ward Care	Per patient per day
Pediatrics	$4.11
Orthopedic	4.10
Ear, nose and throat	3.81
Eye	4.32
Skin and malaria	3.54
Surgical	4.15
Gynecology	4.47
Genito-urinary	3.82
Neurological surgery	4.64
Medical	3.81
Obstetrical (adults)	4.46
Obstetrical (infants)	1.00
Malignancy	3.91
Infected obstetrical	4.23
Jail	5.83
Tuberculosis	3.17
Psychopathic	6.39
Communicable disease	8.54
Neurological medical	4.39

In addition to such charges for ward care, there shall be added charges for the cost of any special services, in accordance with the following schedule:

Special Services	
Ambulance (per patient per day [trip?])	$2.50
Mortuary (per death per day)	2.91
Dental treatments (per visit per day)	1.58
Dental x-rays (per film)	.10
Surgery (per operating room service unit*)	.085
Blood for transfusion (per cubic centimeter if not donated)	.05
Orthopedic services (per operating room service unit*)	.04
Birth room (per operating room service unit*)	.12
Infected obstetrical (per operating room service unit*)	.12
X-rays (plus cost of film according to size and number used, at the following rates: Each film, 14x17 in., 66¢; 11x14 in., 44¢; 10x12 in., 34¢; 8x10 in., 22¢; 6½x8½ in., 10¢; 5x7 in., 12¢.)	
Pelvis	1.98
Skull (routine)	2.69
Skull (special)	4.82
Mandible	1.98
Mastoid	2.69
Facial	1.98
Sinus	2.69
Spine (cervical)	3.40
Spine (anterior, posterior and lateral)	1.98
Spine (multiple)	2.69
Extremity (single)	1.27
Extremity (multiple)	3.40
Shoulder	1.27
Hip	1.98
Thorax	1.27
Chest (adult)	1.27
Chest (child)	2.69
Chest (anterior, posterior and lateral)	1.98
Abdomen (plain)	1.27
Gastro-intestinal	3.40
Gall bladder	3.40
Foreign body	3.40
Kidney, ureter, bladder study	4.82
Fluoroscopies	
Gastro-intestinal with meal	3.33
Gastro-intestinal with enema	1.98
Chest	1.98
To locate foreign body	1.98
X-ray therapy (per hundred roentgen r units)	.72
Radium therapy (per milligram hour)	.04

* Explanation of operating room service unit: *The total operating room service units per operation is obtained by multiplying the actual number of minutes spent by the patient in undergoing the operation by the number of county paid persons in attendance.* The term "operating room" is not confined to surgical operations, but is a general term also applicable to orthopedic and obstetrical services."

EXHIBIT B

Presents:

1. A letter dated November 2, 1937, from Doctor Kress to the Director of the Division of Accounts and Statistics of the Los Angeles Department of Charities.

2. A letter, dated November 10, 1937, from Doctor Kress to the Director, asking for specific information on eighteen items.

3. A letter, dated December 2, 1937, from the Director, in reply to Doctor Kress's letter of November 10, 1937.

* * *

(A letter dated November 2, 1937, from Doctor Kress to the Director of the Los Angeles Department of Charities—Division of Accounts and Statistics, asking for copies of county ordinances on the subject)

* * *

"Los Angeles, November 2, 1937.
Mr. J. C. Greer, Director, Accounts and Statistics,
Department of Charities,
County of Los Angeles,
Los Angeles, California

Dear Mr. Greer:

Referring to your letter of November 1, 1937, in the case of the boy, Robert Espinoza (concerning whom my letter has been referred to you by Mr. Ickes), I note that you state 'under the laws that exist, it is impossible to cross the account off the books.'

Kindly send me copy of the laws that apply in this case, or give me the references thereto.

If the county ordinances have been printed or mimeographed, I take it that it will be possible for you to mail me a copy. I enclose a stamped reply envelope.

Thanking you for your courtesy in this,

727 West Seventh Street.

Yours very truly,

GEORGE H. KRESS, M.D."

* * *

(A letter dated November 10, 1937, to the Director of the Los Angeles Department of Charities—Division of Accounts and Statistics, asking replies to eighteen questions pertaining to the subject)

"Los Angeles, November 10, 1937.

Mr. J. C. Greer,
Director, Accounts and Collections,
County Department of Charities,
Los Angeles, California

Dear Mr. Greer:

Acknowledging your reply of November 8 to my own letter of November 2 (in answer to your own of November 1, 1937), regarding the lad, Robert Espinoza, a former patient at the Los Angeles County Hospital, whose father, Antonio Espinoza, is employed by me on part time as a laborer-gardener (see my previous letters to Superintendent Gray of the Hospital and Assistant Superintendent of Charities Sydney F. Ickes), I am writing to again call attention to the fact that the father, Antonio Espinoza, is on a tentative monthly income of, say, eighty dollars, rents a house, and clothes and feeds himself, his wife and three minor children; further, that you suggest this man pay to the County of Los Angeles the sum of one dollar per month until the sum of some thirty-two dollars or so, at a $4 plus rate per day, for his son's stay at the Los Angeles County Hospital, has been paid to the County of Los Angeles.

To date, no one has given me the information I requested concerning the rules of the County of Los Angeles that determine the dividing line between total or part-pay patients, on the one hand, and no-pay patients on the other.

These new rules of the County of Los Angeles, regarding supposedly indigent patients at the Los Angeles County Hospital, are of much interest to the medical profession, especially since the members of the Attending Medical and Surgical Staff of the institution give gratuitous professional services that annually represent a donation having a money value in excess of one million dollars.

It is our purpose to discuss this subject editorially when the time seems proper, and to that end I would appreciate further information thereon. Attached you will find some suggestive questions on which further knowledge is desired.

I shall appreciate your department giving me such information as comes within its province, but am sending copies also to Mr. Rex Thompson, Superintendent of Charities; Mr. Sydney Ickes, Assistant Superintendent, and Mr. Everett Gray, Superintendent of the Los Angeles County Hospital. A copy also goes forward to Supervisor Leland Ford, because the lad, Robert Espinoza, lives in Mr. Ford's supervisorial district.

Looking forward to replies from the county departments having responsibilities in the matter under discussion, I am

727 West Seventh Street.

Very truly,

GEORGE H. KRESS, M.D.,
Editor."

* * *

(Reply, dated December 2, 1937, of the Los Angeles Department of Charities—Division of Accounts and Statistics, to the letter of November 10, 1937, asking for specific information on matters under discussion)

(Copy)

"County of Los Angeles,
Department of Charities
Los Angeles, California

Bureau of Indigent Relief:
Los Angeles County General Hospital;
Olive View Sanatorium;
Rancho Los Amigos [County Farm]

Los Angeles, December 2, 1937.

Dear Doctor Kress:

This will reply to your letter of November 10, requesting information relative to the collection program of the Department of Charities. I am very glad to have the opportunity to clarify the policies and procedures of this department with respect to collection of indigent accounts, and will endeavor to answer your questions in sufficient detail to enable you to present a comprehensive picture of our program to your associates on the attending staff of the Los Angeles County General Hospital.

Permit me to point out that *patients who have received care at the hospital are billed only for the actual cost to the county of providing hospitalization. Services of the attending staff being gratuitous,* the bills do not represent a charge for such medical attendance as is rendered by the attending physician.

Your specific questions relative to the subject of collections are answered seriatim:

1. Question.—Whether every patient who comes into that hospital is sent a bill, either to himself when he is discharged as a living patient or to his estate in case of death?

Answer.—The hospital business office prepares a bill for every in-patient [10] of the Los Angeles County General Hospital (except patients of the contagious diseases and jail wards), and forwards same to Collection Division. This division accumulates any other charges for services rendered by the Department of Charities and forwards the bill to the client or responsible relative. A bill is not sent to the client, however, during such time as he is the recipient of public charity, it

being obvious that he would have no ability to reimburse.

* * *

[10] Comment.—This statement implies that even the proven indigents are billed for "hospitalization." The last portion of Answer 1 is not clear. If the patient is not an indigent, by what legal right does he become the "recipient of public charity"; that is, become the recipient of public moneys? Granted, however, that he is "such a recipient of public charity," and has means to reimburse the county, why should not a statement for hospitalization services be rendered to him in the same manner as bills are submitted to patients in private hospitals, namely, while he is still in the hospital, with payments in advance?

And on what basis was it construed that it is "obvious that he [the patient] would have no ability to reimburse"?

* * *

2. Question.—Where do these papers accumulate, and in whose charge?

Answer.—All bills for services rendered by any unit of the Department of Charities accumulate in the Collection Division.

3. Question.—Who is the chief of the department; who are deputies in the said department?

Answer.—The Collection Division is in charge of the undersigned, responsible to the Superintendent of Charities.

4. Question.—Who has the final decision on stating whether some accounts shall be nullified, and if they can be nullified, what are the State and county ordinances that permit nullification, and in whom is the authority for nullification vested?

Answer.—Sections 2603 and 2576 of the Welfare and Institutions Code reads as follows:

"2603. If a person for the support of whom public moneys have been expended acquires property, the county shall have a claim against him to the amount of a reasonable charge for moneys so expended and such claim shall be enforced by action against him by the district attorney of the county on request of the board of supervisors. . . ."

"2576. The board of supervisors shall, in the case of aid granted by institutional care, fix a reasonable charge therefor, which shall be the measure of reimbursement to the county, and the existence of the order fixing the charge shall constitute *prima facie* evidence of its reasonableness."

Under the above sections a recipient of county aid is liable for reimbursement at any time he becomes possessed of property.[11] There is no authority for the 'nullification of charges.' In certain instances, the Board of Supervisors has adjusted claims against a recipient of aid, accepting in full payment a lesser amount than the total charges.

* * *

[11] Comment.—In view of an action under consideration by the California Supreme Court as announced in the press on January 5, 1938, and others reasons, the question of the constitutionality of certain Welfare Code provisions comes up for consideration. See Exhibit H, on page 112, for the news item concerning the Supreme Court decision.

* * *

5. Question.—What was the date under which this new ordinance or law went into effect, so far as passage by the Board of Supervisors was concerned?

Answer.—The provisions of law authorizing the county to collect reimbursement for aid to indigents are not new, first appearing in the Statutes of 1901 in substantially the same form as the above quoted sections.[12] The responsibility for collection of such claims against indigent clients of the county is placed upon the Superintendent of Charities by Rule 6N, Section 4, of the County Rules Ordinance 929 NS, which also has been in effect for many years. The only recent enactment by the Board of Supervisors relative to reimbursement was the resolution of June 29, 1937, adopting a new schedule of charges for institutional care, whereby the hospital charges were made to conform, in so far as possible, to the actual cost to the county of providing care.

* * *

[12] Comment.—If the laws governing collections were enacted in the year 1901, and, as is here stated, first applied in their present form on July 1, 1937, who were the county officers who were to blame for negligence during these thirty-six years? And who are the present county officials who made the discovery for the institution of the new system, and what were the recommendations made to the Board of Supervisors for adoption through county resolutions or ordinances?

* * *

6. Question.—When did the bureau or division that has charge of the enforcement of the ordinance become operative?

Answer.—As previously stated, the Superintendent of Charities is responsible for securing reimbursement to the county. The Collection Division of the Department of Charities, as it exists today, was created May 20, 1935. Prior to that time collections for the Department of Charities were handled by the Property Section.

7. Question.—What did they do with the accounts of all the patients who were in prior to the ordinance becoming operative?

Answer.—Following the adoption of the revised schedule of charges, a policy of billing all institutional patients at the time of discharge was placed in effect by this department. Prior to July 1, 1937, billing was restricted to those hospital patients for whom bills were recommended by the Hospital Social Service Department. It was felt[13] that it would be more equitable to bill all patients and then arrange payments in accordance with financial ability, rather than bill only a restricted group selected on the basis of immediate financial ability. Under the new system, the client is made aware of his obligation, even though there is no immediate prospect of payment.

* * *

[13] Comment.—Who were the county officials who had this "feeling," and who gave them the legal advice to proceed as here indicated? And

what is the purpose of an elaborate system of bookkeeping, to carry accounts, which are known in advance to be of no value? This same practice was rather caustically criticized not so long ago in the report of a survey instituted by the county's Bureau of Efficiency, in connection with the out-patient service of the Los Angeles County Hospital.

* * *

8. Question.—Has every patient since the ordinance became operative, without exception, either in person or through his estate, been the recipient of a notice to pay up?

Answer.—Since July 1, 1937, every in-patient has been billed, with the exceptions noted in '(1)' above.

9. Question.—What is the total amount of money that has been received in cash since the Bureau of Collection became operative?

Answer.—In the fiscal year 1936-1937, the Collection Division of the Department of Charities secured county reimbursement totaling $581,-299.23, of which $306,974.02[14] was on Los Angeles County General Hospital accounts.

* * *

[14] Comment.—According to this item, the County of Los Angeles, in the fiscal year July 1, 1936-July 1, 1937, was reimbursed by patients to the amount of $306,974.02. The five hundred members of the attending staff of physicians and surgeons who gave professional services, which have been estimated to have a money value of some two millions of dollars, received not one penny for their services! And, unbelievable as it may seem, up to the present time, in spite of repeated efforts, the attending staff has been unable to even secure an annual printed report of its professional work! Physicians are, indeed, strange mortals as regards the extent to which they carry their altruism (not only to the indigent and near-indigent sick, but to the taxpayers at large).

* * *

10.—Question.—What is the total amount of money that is scheduled in pledges?

Answer.—In this question it is uncertain what was meant by the word 'pledges.' Practically all patients of Los Angeles County General Hospital sign an agreement to reimburse the county for the cost of providing care. If the applicant is possessed of property of an assessed valuation in excess of $250, he is required to give a lien thereon as a condition of receiving aid (Rule 6h, Section 4, County Rules Ordinance 929 NS). In this fiscal year [beginning July 1, 1937] to November 1, 1937, bills were prepared by the hospital business office in the total amount of $1,169,921.87. [Ed. note.—A period of four months. On this basis, the total of bills sent out for 'hospitalization' only, to cover the entire year, would be $3,509,765.61!]

11. Question.—What is the maintenance cost of perpetuating this bureau that sends out all these notices?

Answer.—The cost of actual collection effort for the fiscal year 1936-1937 totaled $109,383.09,[15] or 18.7 cents on the dollar collected. The method of computing this figure was the same as that used by the Grand Jury investigators, who reported a cost of approximately 27 cents on the dollar for the fiscal year 1935-1936. You will note that the cost of collections has been sharply reduced in the last fiscal year.

* * *

[15] Comment.—If hospitalization statements to the amount of $3,509,765.61 will be sent out to County Hospital patients for the present fiscal year, and if again, as during last year, the sum of only $306,974.02 is collected, it would appear that about 90 per cent of the statements might be termed "bureaucratic bookkeeping"! And for what purpose? Would such a system be carried on in business circles? (A letter, dated January 24, 1938, received as this copy was in the hands of the printer, stated: "For the period July 1 to December 31, 1937, the amount representing the sum of all bills which have been sent to this division from the General Hospital represents $2,366,779.30. This represents 32,469 bills referred to us by the Los Angeles County General Hospital." The above was for the first six months. For the entire year, on that basis, $4,733,588.60 would represent the total amount of bills sent out!)

* * *

12. Question.—What is the pro rata maintenance cost of any other county departments that do part of the work of notification or of collection from these supposedly indigent patients?

Answer.—No figures are available on the cost to the institutions of preparing bills, this work being an integral part of the respective business offices.

13. Question.—What are the numbers of the ordinances, the dates on which passed, and the exact text of the ordinances that apply to this work?

Answer.—As previously cited: Sections 2603 and 2576 of the Welfare and Institutions Code.

14. Question.—What are the numbers of the ordinances; the dates on which passed; and the exact text of the ordinances that apply to this work?

Answer.—Rule 6, Section 4, County Rules Ordinance 929 NS (adopted October 1, 1923, and frequently amended), prescribes certain eligibility requirements for county aid, including the lien provision and the section making it mandatory upon the Superintendent of Charities to attempt collections.[16]

* * *

[16] Comment.—As previously stated, and especially in view of the recent California Supreme Court action, the question of instituting a test case to determine the constitutional points involved might well become a matter quite worthy of consideration.

The "frequently amended" rule concerning "eligibility requirements for county aid, including the

lien provision," should be carefully studied, from both the legal and social welfare standpoints.

* * *

15. Question.—What other counties and states have this?

Answer.—Unknown.

16. Question.—By whom were these proposed ordinances submitted to the Board of Supervisors, and through what committee of the Board of Supervisors were they presented to the entire Board for enactment?

Answer.—Probably[17] these orders were prepared by County Counsel at the express request of the Board.

* * *

[17] Comment.—The word "probably" seems out of place. It seems curious that the director of a county department division, which department sends out statements each year to the amount of $3,509,765.61, should not have, in the records of his office, the memoranda showing the official actions of the county's Board of Supervisors upon which the legal authority for his procedures must be based!

* * *

17. Question.—What portions of the Kern County Hospital Appellate Court Opinion is being used by the County Hospital as a basis for charging practically all patients a per day residence rate?

Answer.—The basis for claiming reimbursement from a county client is found in the previously cited section of the Welfare and Institutions Code; *not* in the Kern County decision.[18] The Kern County decision was taken into account, however, when the Board of Supervisors was requested to adopt a new schedule of charges for hospital care, based on a cost accounting system, to supersede the old flat charge rate of $4.00 per day. On this subject the Court expressed the following views:

"The defendants estimated the cost of hospitalization in the County Hospital at three dollars per day per patient. In arriving at this figure, no account was taken of a capital investment of several hundred thousand dollars, nor of depreciation. The amount of daily cost was reached by taking the total number at the Hospital, which included the dependent aged, as the divisor, and the total spent for the operation of the Hospital as the dividend, and dividing the result thus obtained by the number of days in the year. It is obvious that the daily cost of caring for an aged poor person who does not require hospitalization would not be as great as that of a strictly hospital patient. It is also obvious that the average daily cost of care and treatment of a patient hospitalized for a simple illness would not be as great as that of a strictly hospital patient. It is also obvious that the average daily cost of care and treatment of a patient hospitalized for a simple illness would not be as great as that of a serious operative case. The method used in reaching the daily cost per patient was so inaccurate and unbusinesslike that the result could not reflect the true daily cost to the county of any one patient. This must have resulted in gifts of county money to at least those patients who paid nothing and to those who paid only three dollars per day and who were serious operative cases."

* * *

[18] Comment.—See also Comment No. 7, previously considered, in re: Kern County Hospital opinion. It is suggested that a careful study of the Kern County Appellate Court decision be made by competent legal advisors of the county, and written opinions recorded, before bureau or other chiefs be given authority to make interpretations thereon that may be in error.

* * *

18. Question.—Any other pertinent information on the subject?

Answer.—Therefore, to conform with latest legal precedent on subject, the Department of Charities initiated the policy of billing clients on the basis of the actual cost of services rendered. The ultimate amount paid by the client is determined by his future resources, if any, and payments are adjusted according to financial ability. As the so-called Kern County decision runs counter to the acceptance of full-pay patients[19] by the county hospitals (with certain exceptions) this department has attempted to reconcile the views of the court to the provisions of law regarding reimbursement in a manner permitting the practical appliance without running contrary to legal interpretation.

* * *

I trust that the answers to your questions are sufficiently clear, and will be glad to give you any further information on the subject that you may desire.

Yours very truly,

Rex Thomson,
Superintendent of Charities.

By J. C. Greer,
Director, Accounts and Statistics.

* * *

[19] Comment.—The phraseology of this sentence leaves one in doubt as to whether this new system of collection was instituted independently, or with the written consent of the county's legal department.

Equally strange is the reference to "full pay patients." Up to now, it has been generally thought that the county hospitals of California were intended, by constitutional and legislative provisions, to provide hospitalization and medical care only for indigent or near-indigent persons who were sick or injured. As we read it, the Appellate Court decision in the Kern County Hospital case would so indicate. This view is also confirmed by the informal opinion, written on short notice, by Mr. Hartley Peart, general counsel of the California Medical Association. (See Exhibits D and E for these, pages 108 and 109.)

Occasionally, it has been stated that county employees not suffering from emergency illnesses or injuries have received treatment. If such cases are on record, investigation should be made to determine whether statements were sent to such patients, and also whether reimbursement was made. Another item for investigation would be amount of reimbursement made by insurance carriers for care to industrially injured citizens (Industrial Act of California).

EXHIBIT C

Presents:

1. The "form letter" which is sent to every inpatient after his dismissal from the Los Angeles County Hospital.

2. "Sample" of an actual statement rendered to a patient on the obstetrical service.

* * *

"County of Los Angeles
Department of Charities
Los Angeles, California

September 27, 1937.

Address reply to: Collection Division, Room 210, 434 S. San Pedro Street.
Re: ————
File No.————
Mr. ————
———— Street
Los Angeles, California
Dear Mr. ————

The account for aid advanced by the Department of Charities—County of Los Angeles, as shown above, has been referred to this office for collection.[20]

Remittance for the full amount should be made by return mail. If this is not possible because of financial conditions, *it will be necessary for you to call at this office on or before* (date) to arrange a definite plan of settlement consistent with your ability to pay.

Remittances are to be made payable to Department of Charities—County of Los Angeles, and mailed to this office. Kindly keep us informed of any change of address.

Your prompt attention is anticipated.

Yours very truly,
DEPARTMENT OF CHARITIES
Collection Division
By ————

Notice: Please bring or return this letter with remittance. All aid advanced by the Department of Charities is collectible from the party receiving such aid, or from legally responsible relatives, as provided by State Law and County Ordinance. If care is given in any County Institutions, collection at the full legal rate established by the Board of Supervisors is at all times enforceable."

* * *

[20] Comment.—Attention is called to the language used in this letter, in which reimbursement to the County of Los Angeles is practically demanded of indigent and near-indigent patients, no mention being made of the fact that attending physicians have given the medical and surgical services without cost to patients or taxpayers. As a matter of fact, to the untutored, and to those who are not such, the phrase, "aid advanced by the Department of Charities," would seem to imply not only hospitalization (board, ward bed and nursing), but also professional services! Probably nine out of ten of the unfortunate citizens receiving such statements so construe the meaning of the letter. It is not difficult to imagine the consternation which must many times come to a poor wage earner, or indigent citizen, on receiving, of a sudden, such a letter, with the statement of his indebtedness for a large sum, to cover the cost of board, room and nursing given by the County of Los Angeles, which, in many cases, the patient and relatives thought were being supplied without cost.

* * *

Copy of Statement

Statement (date)
File No. ———

Aid advanced to ———— Baby
Address: As below
City: Los Angeles, California
Aid advanced by LACGH [Los Angeles County General Hospital]
Bill to ————
Address: Los Angeles, California
To County of Los Angeles,
Department of Charities
Collection Division
434 South San Pedro Street,
Los Angeles, California

* * *

Excerpts from Statement
(Copy)

Date	*Description*	*Charges*	*Balance*
	Statement for Infant		
Oct. 5-17, 1937	Obstetrical ward (infant) twelve days at $1	$ 12.00	$ 12.00
	Statement for the Mother		
Oct. 5- 8, 1937	Obstetrical ward (adult) four days at $4.46	$ 17.84	
Oct. 9-17, 1937	Infected obstetrical ward (adult) eight days at $4.23	33.84	
Oct. 5, 1937	Ambulance to hospital	2.50	
Oct. 5, 1937	Operative — Cesarean section[21]	136.80	
Oct. 9, 1937	Operative — Blood transfusion (450 cc.)	22.50	
Oct. 9, 1937	X-ray of chest	1.93	$215.41

* * *

[21] Comment.—The item in the statement sent to this particular patient for the use of the operating room and the services of its nursing personnel (for that is what is meant by the euphonious and misleading words, "Operative—Cesarean Section.....$136.80") is little less than appalling! For comparison, in the California Hospital, of Los Angeles, the use of the operating room for a cesarean section would be $10, and at the Cedars of Lebanon Hospital, $12.50. But the County of Los Angeles charged this supposedly indigent patient, for the same hospitalization not one whit better, the extraordinary sum of $136.80! Because of such extortionate charges, included in statements sent out by the County of Los Angeles, complaints are beginning to come in from all parts of the county—to the Public Health Committee of the Los Angeles Chamber of Commerce, to physicians and others. If a circular letter were to be sent to all patients who have been billed in the last six months, some most astounding and heart-rending revelations would, no doubt, be forth-

coming! Will such an investigation be made by the constituted public authorities who have responsibility in this?

The charge of $136.80 was evidently based on the illuminating footnote, "Explanation of Operating Room Service Unit," attached to Superintendent Gray's fee table, as given in Exhibit A, on page 100, with estimate *charges of so much per minute!* It will be interesting to learn what party or parties will now assume the responsibility for having promulgated the aforesaid fee table of hospitalization charges.

In the above excerpts from the statement under discussion, the words "Operative—Cesarean Section" certainly indicate "professional service" rather than "hospitalization." If such be the case, is not then a statement so rendered an example of frank misrepresentation? And if so, should such a practice be countenanced or continued?

EXHIBIT D

Presents:

1. The full opinion of the California Appellate Court (Fourth District) handed down on January 30, 1936, and presumably used as a partial or complete justification for the institution of a new system for securing reimbursement for hospitalization services from former county hospital patients. The court's rulings are practically all included under Item 8 of the opinion, and a careful perusal of that item is suggested, especially since its substance is referred to in several of the exhibits here presented. (See page 108 for Item 8.)

* * *

PUBLIC HOSPITALS IN CALIFORNIA CANNOT HOSPITALIZE NON-INDIGENT PATIENTS*

OPINION OF THE APPELLATE COURT (FOURTH DISTRICT) AFFIRMING DECREE OF INJUNCTION RENDERED BY SUPERIOR COURT JUDGE K. VAN ZANTE

Because of its medical and legal importance and interest to the citizens and medical profession of the State of California, the opinion of the Appellate Court rendered on January 30, 1936, affirming, as modified, the decree of judgment rendered on December 4, 1933, in the Superior Court of Kern County, California, by Judge K. Van Zante is reprinted. Since this decision was handed down on January 30, 1936, it has been frequently referred to, especially in connection with county hospitals in California, whose administrators were extending the scope of such public institutions, into fields beyond their original scope.

The Appellate Court opinion follows.

* * *

Civil No. 1761. Fourth Appellate District

January 30, 1936

O. P. Goodall, T. M. McNamara, P. J. Cuneo, S. C. Long, H. N. Brown, F. J. Gundry, C. S. Compton, W. H. Moore, L. H. Fox, and L. C. McLain, Plaintiffs and Respondents, vs. Perry Brite, Stanley Abel, W. R. Woollomes, J. O. Hart, and Charles W. Wimmer, individually and as members of the Board of Supervisors of Kern County, and Kern County, a legal subdivision of the State of California, Defendants and Appellants.

[1] *Constitutional Law—Public Money—Gifts.*—Section 31 of Article IV of the Constitution prohibits cities and counties from making any gifts of public funds and from using public funds for private purposes, and the legislature cannot authorize the use of county funds for any such purpose.

[2] *Id.—Counties—Hospitals.*—While the board of supervisors of a county has the general power to adopt rules and regulations for the operation of a county hospital, that power must be exercised within the limits of their constitutional powers.

[3] *Id.—Public Health—Police Power.*—The promotion of the public health and general welfare of the citizens of a county falls within the powers granted to counties by Section 11 of Article XI of the Constitution.

[4] *Id.—Counties—Hospitals—Public Health—Police Power—Public Money—Gifts.*—The admission and treatment of patients in a county hospital who, either themselves or through legally responsible relatives, can provide themselves with equally efficient care and treatment in private institutions in the county does not promote the health and general welfare of the citizens of the county and is not a proper exercise of the police power of that county, but results in the use of public money for private purposes in violation of Section 31 of Article IV of the Constitution.

[5] *Id.—Indigents—Hospitals—Public Health—Police Power.*—A patient in need of hospitalization, who cannot himself, or through legally liable relatives, pay the charges of a private institution, but who can pay something toward his care and treatment in the county hospital, should be admitted to the county hospital because the care of such sick and injured promotes the public health and general welfare of the community in which he lives.

[6] *Id.—Counties—Hospitals—Statutory Construction.*—In this action to enjoin defendant board of supervisors from admitting certain classes of patients to the county hospital, there was no merit in the contention that as the legislature has provided that certain classes of patients in the county hospitals may pay for their care, under the maxim, "Expressio unis est exclusio alterius," the members of no other class who can contribute to their care can be admitted, and that as it is provided that those belonging to certain classes shall be admitted, no others can be received.

[7] *Id.—Hospitals—Emergency.*—In such action, the injunction issued by the trial court should have provided that in cases of accident or sudden illness, or of public disaster, such as fire, earthquake, floods, storms or epidemics, people injured or rendered suddenly ill, and for whom immediate hospitalization is made necessary, should be admitted promptly; but in such cases investigation should be made of their abilities to pay for the services rendered, and the Board of Supervisors should not hesitate to collect the full cost of hospitalization from those able to pay, and from others not able to pay in full, a fair amount, to be determined after an investigation of their resources.

[8] *Id.—Injunction—Statutes.*—In such action, the injunction issued by the trial court was not sufficiently elastic, in that it failed to provide for any contingency arising from changes in state legislation relating to the classes to be admitted and the conditions of admissions to county hospitals.

Appeal by defendants from a judgment of the Superior Court of Kern County, K. Van Zante, Judge, in an action for an injunction. Affirmed as modified.

For Appellants—Thomas Scott, District Attorney; W. A. McGinn, Assistant District Attorney; Borton & Petrini, Special Counsel.

Amici Curiæ for Appellants — Nutter & Rutherford, Stephen Dietrich.

For Respondents—Siemon, Claflin & Maas; Hartley F. Peart; Finlayson, Bennett & Morrow.

Amici Curiæ for Respondents—Elvon Musick, Howard Burrell, E. Perry Churchill.

* * *

*The plaintiffs are citizens and taxpayers of the County of Kern. The individual defendants are the members of the Board of Supervisors of the county.**

Kern County maintains a hospital for the hospitalization of the sick and injured as well as for the care of the indigent poor and indigent aged of the county. The hospital is a well-equipped institution. With the tacit, if not the express, consent of the supervisors, it is the practice to admit as patients persons well able to pay for hospitalization in private institutions, either themselves or through relatives legally liable for their support and, also, persons who can pay only part of the cost of their hospitalization in the county institution and who obviously cannot pay the higher costs of private hospitalization. *The plaintiffs challenged the right of defendants to use county funds to provide hospital care for these two classes of patients except in certain instances where such practice is permitted by statute.*

It is freely conceded by counsel for defendants that they have provided hospitalization in the county hospital for these two classes of patients and that they will continue to do so if not enjoined by order of court. It is also ad-

* This caption and its subhead, with introductory paragraph, are reprinted from CALIFORNIA AND WESTERN MEDICINE, March, 1936, on page 189.

* Editor's Note.—Italics our own.

mitted that in the past both these classes of patients have been asked to make "donations" toward the cost of their hospitalization; that no charges have been made against them and that no effort has been made to collect from any of them where the donations had not been made. It is also apparent from the evidence that some citizens of Kern County who were financially able to pay for hospitalization and treatment in private institutions had been hospitalized for considerable periods of time in the county hospital without making any payments therefor. The trial court, on ample evidence, found there were sufficient private hospitals in Kern County to satisfactorily care for all cases hospitalized in the county hospital where the patients, or relatives legally liable for their support, could have paid for private hospitalization. Therefore, we do not have presented here any question of the right of a county hospital to receive a patient possessing substantial means where there was no other hospital within a reasonable distance which could afford him proper care and treatment.

Boards of supervisors are given the express power to establish and maintain county hospitals and to provide rules for their government and management. (Sec. 4223, Political Code.) A like power is given them to establish and maintain almshouses and county farms. (Sec. 4224, Political Code.) In Kern County the poor are cared for at the county hospital. Therefore, it is a combination county hospital and almshouse.

Defendants maintain that as the Board of Supervisors of Kern County is given the power to "establish" and "maintain" a county hospital and provide rules for its "government" and "management," the question of who shall be admitted and upon what terms is within the sound discretion of the board and cannot be controlled by injunction. They also urge that Section 11 of Article XI of the Constitution vests in counties police powers which are as broad as those possessed by the state, except where prohibited by statute. From this they argue that as the promotion of the health of the residents of Kern County, as well as the promotion of their general welfare, is one of the principal police powers given under this section they may admit to the hospital any resident of Kern County possessing the necessary qualifications of residence regardless of his ability to pay and without making any charge against him.

We will first consider these questions from the point of view of the admission to the hospital of those patients who either themselves, or through legally liable relatives, are able to secure and pay for hospitalization and treatment in private institutions.

Section 31 of Article IV of the Constitution "took from the legislature the power to give, lend, or authorize the giving or lending of the state's credit, or that of any county, city and county, city or township, or other political corporation or subdivision of the state, in aid of or to any person, association, or corporation, municipal or otherwise, or to pledge the credit thereof in any manner whatever, for the payment of the liabilities of any individual, association, municipal or other corporation, whatever; or to make or authorize the making of any gift of any public money or thing of value to any individual, municipal or other corporation whatever.

"These limitations divested the legislature of all power to make appropriations of money to any private or quasi-public corporation or to make any gift to any municipal or public corporation not under the exclusive control and management of the state. It also deprived the legislature of the power to authorize counties to make donations or gifts or pledges of credit to such associations. *The Constitution does not give to any department of the state government any power whatever to engage in private business or enterprise, or to manage and control private corporations or quasi-public corporations for private profit, although such corporations may be carrying on enterprises or performing functions which are for general public benefit and which tend to promote the general welfare. Our state government has no such powers." (People* vs. *San Joaquin Valley etc. Assn.*, 151 Cal. 797.)

[1] *It has been held that this same section of the Constitution prohibits cities and counties from making any gifts of public funds and of using public funds for private purposes. (Pacific Mutual Life Ins. Co.* vs. *County of San Diego*, 112 Cal. 314; *City of Oakland* vs. *Garrison*, 194 Cal. 298; *Chapman* vs. *City of Fullerton*, 90 Cal. App. 463.) The legislature cannot authorize the use of county funds for any such purposes. (*Conlin* vs. *Board of Supervisors*, 99 Cal. 17; *Conlin* vs. *Board of Supervisors*, 114 Cal. 404; *Johnston* vs. *County of Sacramento*, 137 Cal. 204.)

[2] *It must be conceded that while the board of supervisors has the general power to adopt rules and regulations for the operation of the Kern County hospital, that power must be exercised within the limits of their constitutional powers. It must be further conceded that if their acceptance for hospitalization of patients who, themselves, or through legally liable relatives can provide efficient hospitalization elsewhere, amounts to a gift of public funds to private persons which is prohibited by Section 31 of Article IV of the Constitution, its continuance may be enjoined by the courts.*

In discussing the extent of the grant of police powers to municipalities by Section 11 of Article IV of the Constitution the Supreme Court in the case of *Miller* vs. *Board of Public Works*, 195 Cal. 477, said: "The police power of a state is an indispensable prerogative of sovereignty and one that is not to be lightly limited. Indeed, even though at times its operation may seem harsh, the imperative necessity for its existence precludes any limitation upon its exercise save that it be not unreasonably and arbitrarily invoked and applied. (*Hadacheck* vs. *Sebastian*, 239 U. S. 394, Ann. Cas. 1917B, 927, 60 L. Ed. 348, 36 Sup. Ct. Rep. 143; *District of Columbia* vs. *Brooke*, 214 U. S. 138, 149, 53 L. Ed. 941, 29 Sup. Ct. Rep. 560; see, also, Rose's U. S. Notes.) It is not, however, illimitable, and the marking and measuring of the extent of its exercise and application is determined by a consideration of the question of whether or not any invocation of that power, in any given case, and as applied to existing conditions, is reasonably necessary to promote the public health, safety, morals (*Hannibal etc. R. R. Co.* vs. *Husen*, 95 U. S. 465, 470, 471, 24 L. Ed. 527; *Boston Beer Co.* vs. *Massachusetts*, 97 U. S. 25, 24 L. Ed. 989), or general welfare of the people of a community. (*Chicago, B. & Q. Ry. Co.* vs. *Illinois*, 200 U. S. 561, 592, 4 Ann. Cas. 1175, 50 L. Ed. 596, 26 Sup. Ct. Rep. 341; see, also, Rose's U. S. Notes.) . . .

"In its inception the police power was closely concerned with the preservation of the public peace, safety, morals, and health without specific regard for 'the general welfare.' The increasing complexity of our civilization and institutions later gave rise to cases wherein the promotion of the public welfare was held by the courts to be a legitimate object for the exercise of the police power. As our civic life has developed so has the definition of 'public welfare' until it has been held to embrace regulations 'to promote the economic welfare, public convenience and general prosperity of the community.' (*Chicago, B. & Q. R. R. Co.* vs. *Illinois, supra.*) Thus, it is apparent that the police power is not a circumscribed prerogative, but is elastic and, in keeping with the growth of knowledge and the belief in the popular mind of the need for its application, capable of expansion to meet existing conditions of modern life and thereby keep pace with the social, economic, moral, and intellectual evolution of the human race. In brief, 'there is nothing known to the law that keeps more in step with human progress than does the exercise of this power.' (*Streich* vs. *Board of Education, supra*), and that power 'may be put forth in aid of what is sanctioned by usage, or held by the prevailing mortality or strong and preponderant opinion to be greatly and immediately necessary to the public welfare.' (*Noble State Bank* vs. *Haskell*, 219 U. S. 104, Ann. Cas. 1912A, 487, 32 L. R. A. [N. S.] 1062, 55 L. Ed. 112, 31 Sup. Ct. Rep. 186; see, also, Rose's U. S. Notes.)" See, also, *Coelho* vs. *Truckell*, 82 Cal. App. Dec. 639.

In *Jardine* vs. *City of Pasadena*, 199 Cal. 64, it is said: "The selection of the hospital site was a matter within the legislative discretion of the board of directors of the city, and unless in the exercise of that discretion the board acted arbitrarily and unreasonably, its action ought not to be enjoined.

" 'The location, establishment and maintenance of such an institution is clearly within the scope of the police power of the city. General police authority to protect the public health is conferred upon the city by Section 11 of Article XI of the State Constitution, which provides that "any county, city, town, or township may make and enforce within its limits all such local, police, sanitary and other regulations as are not in conflict with general laws." ' "

[3] It follows as an inescapable conclusion from what has been said in the cases from which we have quoted that the promotion of the public health and general welfare of the citizens of Kern County falls within the powers granted to the county by Section 11 of Article XI of the Constitution. *Does the hospitalization in the county hospital of those able to secure efficient hospitalization in other institutions promote the health and general welfare of the citizens of Kern County? The answer to this question will determine whether that policy falls within the protection of the provisions of Section 11, and also whether the expenditure of public funds for that purpose amounts to a use of them for a public purpose or gifts to private persons.* This last follows, because, if the use of the money for the purposes specified promotes the health or general welfare of the people of Kern County, that in itself should be held to be expenditures for a public purpose and not gifts to private persons.

[4] In approaching this question it should be borne in mind that the record establishes the fact that there are excellent privately owned hospitals in Kern County with sufficient facilities to care for those who can pay for their care and treatment. It seems, therefore, that the question is not so much the preservation of the health and general welfare of the financially able citizens of the county as it

is one of the preservation of their private resources. If a patient can be given the same and equally efficient care and treatment in a private hospital that he can receive in the county institution, his choice of a hospital does not determine his chances of recovery but merely the amount he must pay to be healed, and whether he will pay the established charge of a private institution, or nothing or the small donation hoped for by the county hospital. The preservation of the health and general welfare of the citizens of the county is a question of the prevention and cure of disease generally, and not the accomplishment of these ends by any particular means or in any particular institution. *We, therefore, conclude that the admission and treatment of patients in the county hospital who, either themselves or through legally responsible relatives, can provide themselves with equally efficient care and treatment in private institutions does not promote the health and general welfare of the citizens of Kern County and is not a proper exercise of the police power of that county and results in the use of public money for private purposes.*

We have further facts in the record bearing upon the question of the use of public money for private purposes. The defendants estimated the cost of hospitalization in the county hospital at three dollars per day per patient. In arriving at this figure no account was taken of a capital investment of several hundred thousand dollars, nor of depreciation. The amount of daily cost was reached by taking the total number at the hospital, which included the dependent aged, as the divisor, and the total spent for the operation of the hospital as the dividend, and dividing the result thus obtained by the number of days in the year. It is obvious that the daily cost of caring for an aged poor person who does not require hospitalization would not be as great as that of a strictly hospital patient. It is also obvious that the average daily cost of care and treatment of a patient hospitalized for a simple illness would not be as great as that of a serious operative case. *The method used in reaching the daily cost per patient was so inaccurate and unbusinesslike that the result could not reflect the true daily cost to the county of any one patient.* Thus must have resulted in gifts of county money to at least those patients who paid nothing and to those who paid only three dollars per day and who were serious operative cases.

[5] When we approach the question of those patients who are admitted to the county hospital and who cannot pay for hospitalization in private institutions but who can pay something toward their care and treatment, we have an entirely different situation from the one we have been considering. We must bear in mind that providing hospital facilities to those legally entitled thereto is a proper exercise of the police power of the county (*Jardine* vs. *City of Pasadena, supra*) as it tends to promote the public health and general welfare of the citizens of the county. (*Miller* vs. *Board of Public Works, supra.*) In the second phase of the case we have the problem of the care of the health and the promotion of the general welfare of what we may term the deserving needy but not the pauper class of the county. This class must be hospitalized at the county hospital or permitted to suffer without proper care. It is common knowledge that this class composes a considerable proportion of the body of the citizenship of any county. As a rule those composing it are honest, industrious, and often thrifty people whose welfare should be of first concern to any governmental agency. *It is admitted that a resident pauper must be hospitalized at public expense.* This is a matter of pure humanity and no one, solely because of poverty, should be permitted to suffer because of lack of funds. The same reasons apply with greater force to the class we are considering. We can visualize the head of a family who has employment and can keep it—an honest worker, frugal and thrifty, who supports his family, educates his children, and has perhaps acquired an equity in a modest home. If he is injured, not in the course of his employment, the family income stops and he may require hospitalization and may lack the funds with which to enter a private institution. Must it be said that he should be refused admission to the county hospital because he is not a pauper when if he were a pauper he would be admitted without question? This would amount to the penalizing of honest industry, thrift and independence, and would place a premium on indolence and shiftlessness. *Under the principles of humanitarianism, and in the interest of a sound policy, we are compelled to hold that a patient in need of hospitalization, who cannot himself, or through legally liable relatives, pay the charges of a private institution, should be admitted to the county hospital because the care of such sick or injured promotes the public health and general welfare of the community in which he lives.*

If it were necessary we could find another satisfactory reason for the admission of this class of patients to the county hospital. *It is admitted that indigent persons are to be admitted when in need of hospitalization. As far as we know the term "indigent" has not been defined in California in so far as its use in connection with admissions to county hospitals is concerned.* It has been defined in other states chiefly in connection with the admission of the indigent insane to hospitals. *The term when thus used has been held to include persons with insufficient means to pay for hospitalization after providing for those who legally claim their support. (Depue* vs. *District of Columbia,* 45 App. D. C. 54; *In re Hybart,* 119 N. C. 359, 25 S. E. 963; *Mass. Gen. Hospital* vs. *Inhabitants of Belmont,* 233 Mass. 190, 124 N. E. 21; *People* vs. *Board of Supervisors,* 121 N. Y. 345, 24 N. E. 830). *Applying this definition to the instant case, we hold that the word "indigent," when used in connection with admissions to county hospitals, includes an inhabitant of a county who possesses the required qualifications of residence, and who has insufficient means to pay for his maintenance in a private hospital after providing for those who legally claim his support.*

[6] Under the maxim, "Expressio unis est exclusio alterius," it is urged that as the legislature has provided that certain classes of patients in the county hospitals may pay for their care, the members of no other class who can contribute to their care can be admitted, and, further, that as it is provided that those belonging to certain classes shall be admitted, no others can be received.

We cannot agree with this argument. Boards of supervisors are given broad powers in providing for the establishment and maintenance of county hospitals and in prescribing rules for their government and management. (Sec. 4223, Political Code.) *The word "management" has been frequently defined when used in legal phraseology.* When used in a statute giving the husband management and control over his wife's property it has been held to mean that it gave him the power to invest her money. (*Sencerbox* vs. *First National Bank,* 14 Idaho 95, 93 Pac. 369.) When used in the title of an act relating to reform schools, it was held to include provisions in the act providing for the committing of certain juveniles to the schools. (*In re Sanders,* 53 Kan. 191, 36 Pac. 348.) See, also, *Watson* vs. *Cleveland,* 21 Conn. 538; *Commissioners of the Sinking Fund* vs. *Walker,* 7 Miss. [6 How.] 143; *In re Brennan's Will,* 251 N. Y. 39, 166 N. E. 797; *City of Topeka* vs. *Independance Ind. Co.,* 130 Kan. 650, 287 Pac. 708; *Stagway* vs. *Riker,* 84 N. J. Law 201, 86 Atl. 440. *When a board of supervisors is given management of a county hospital, that body is given the power to adopt rules for the admission of patients, provided, of course, that they must admit those entitled by law to enter and cannot admit those whose reception is prohibited by law of the Constitution.* In their rules of admission they should have the power to provide for the payment for care by those not financially able to secure hospitalization in a private institution, the amount to be paid to be determined to its maximum by the cost to the county of hospitalization of each individual patient and charged to the patient on his ability to pay. In the administration of public funds the supervisors are acting as trustees and they should so administer those funds as to lighten the taxpayers' burden as much as possible.

[7] *Another class of patients which should be admitted to county hospitals deserves our consideration.* In cases of public disaster, such as fire, earthquake, floods, storms, or epidemics, people may be injured or rendered suddenly ill and immediate hospitalization may be necessary to save life. The same is true in cases of accident or sudden illness. In such cases, delays in admissions to permit investigations of the financial conditions of the patients might cause loss of life. Such patients should be admitted promptly, investigation of their abilities to pay should follow. Ordinary humanity could dictate no other course. In such cases boards of supervisors should not hesitate to collect the full cost of hospitalization from those able to pay, and from others not able to pay in full, a fair amount, to be determined after an investigation of their resources. We have stricken clause "i" from the decree of the trial court and have added another under the same letter to provide for such cases.

* * *

[8] The decree in this case is not elastic. Over a period of years the legislature has changed and increased the classes to be admitted to county hospitals. That body may continue with such legislation and many provide for the admission of new classes, or restrict those now admitted, or place new conditions upon admissions. To take care of this contingency we have added clause "j" to the decree.

Defendants complain that the decree as rendered is uncertain in several particulars. Plaintiffs in effect admit the charge by proposing amendments to it. We have studied the decree as amended by them and have concluded that it substantially meets the objections of defendants. On our own motion we have stricken one paragraph which plaintiffs proposed to retain as we regard it as surplusage.

It is ordered that the decree of injunction rendered by the trial court on December 4, 1933, be modified by striking therefrom the words, letters and figures not appearing in the decree of injunction hereinafter set forth and adding the words, letters and figures appearing in the decree of injunction hereinafter set forth which do not appear in the said decree signed by the trial judge *so that the decree of*

injunction in this case shall read as follows: (Following the title of the court and cause.)

"The above-entitled matter having been heretofore heard and determined by the undersigned Judge of the Superior Court of the State of California, written findings of fact and conclusions of law having been heretofore duly and regularly signed and filed herein ordering judgment in favor of the above-named plaintiffs and against the above-named defendants as hereinafter given and made, and the case being in all respects ready for final judgment and decree:

"It is therefore ordered, adjudged, and decreed that the defendants Perry Brite, Stanley Abel, W. R. Woollomes, J. C. Hart, Charles W. Wimmer, individually, and as members of the Board of Supervisors of Kern County, and Kern County, a legal subdivision of the State of California, and each of them, and every officer, deputy, agent, appointee, subordinate, servant or employee of the above-named defendants, or either or any of them, and particularly and especially the officers, deputies, agents, employees, appointees, servants, doctors, superintendents, heads of departments, internes, nurses, and assistants, and all other persons acting under defendants or any of them in any matter relating to the operation, maintenance, administration, or conduct of that certain County Hospital of the County of Kern known as the Kern General Hospital, be, and each of such persons *is, and all of them are hereby forever permanently restrained, enjoined, and commanded to desist from admitting to and receiving as patients of, caring for, curing, treating, boarding, nursing, furnishing food or supplies or lodging to, or hospitalizing in, said Kern General Hospital, or at or in any out-patient clinic thereof, any person:**

Who, after due injury and investigation is not found to be an indigent person as herein defined,

or a dependent or partially dependent person in case of emergency,

or who is found, after due inquiry and investigation, to be a person who is himself, or has a relative or relatives legally liable for his support, able to pay for and obtain proper and necessary medical or surgical or hospital care or treatment or services for himself elsewhere than in the county hospital except as hereinafter specified.

The following should be admitted:

(*a*) An indigent sick or dependent poor person.

(*b*) A needy sick and dependent or partially-dependent citizen in case of emergency.

(*c*) A psychopath, narcotic addict or habitual inebriate temporarily in custody.

(*d*) A physically defective and physically handicapped person under the age of eighteen years when the parents or guardians of such person are not financially able to secure proper care or treatment and when such person's admission and treatment has been duly authorized in the manner provided by law.

(*e*) A person in the active stages of tuberculosis, in wards established for the treatment of such persons, who is able to pay for such treatment and who, when able to pay, is required to pay for such treatment.

(*f*) A person to be quarantined or isolated in the county hospital with a contagious, communicable or infectious disease.

(*g*) A prisoner confined to any city or county jail who requires medical or surgical treatment necessitating hospitalization where such treatment cannot be furnished or supplied at such jail when the Superior Court of the county shall have ordered the removal of such prisoner to the county hospital and said prisoner elects not to furnish such treatment at his own expense.

(*h*) A county employee injured in the course of his employment by the county when hospitalization is reasonably required to cure and relieve the effects of such injury.

(*i*) A person in need of immediate hospitalization on account of accident or sudden sickness or injury or by reason of sickness or injury caused by or arising in a sudden public emergency or calamity or disaster. Provided,

(*j*) Nothing in this decree shall be construed as restraining defendants from obeying or carrying out or giving effect to any law that may be passed hereafter relating to the hospitalization of patients in county hospitals which may affect the hospital in Kern County.

"It is further ordered that plaintiffs have their costs herein expended taxed at $306.62.

"Done in open court this fourth day of December, 1933.

"K. Van Zante, Judge of the Superior Court."

As so modified the judgment is affirmed. Each party will pay their own costs on appeal.

Marks, J.

We concur:
Barnard, P. J.
Jennings, J.

* Editor's Note.—This last paragraph in the Opinion has been broken down into subparagraphs for greater convenience in perusal.

EXHIBIT E

Presents:

1. A letter dated January 17, 1938, from Doctor Kress to the General Counsel of the California Medical Association, requesting informal comment to certain questions concerning the Kern County Appellate Court decision.

2. Reply dated January 19, 1938, of General Counsel Peart to the above letter.

* * *

(A letter dated January 17, 1938, from Doctor Kress to Mr. Hartley F. Peart, General Counsel of the California Medical Association, requesting informal comment to some questions concerning the Kern County Appellate Court decision)

"Los Angeles, January 17, 1938.

Mr. Hartley Peart,
1800 Hunter Dulin Building,
111 Sutter Street, San Francisco, California

Dear Hartley:

I dislike to bother you with new queries, but, as stated at the California Medical Association Council meeting on January 15, the admission of patients to county hospitals, who are neither 'pauper indigents' nor 'medical indigents' is a matter of pressing importance.

In the March, 1936, California and Western Medicine, page 189, you will find the Appellate Court decision in the Kern County Case, and I am asking you for an informal legal opinion on certain of its provisions. . . .

Try to send me some informal notes, but promptly, because they may be of help in editorial and other comment.

Cordially yours,
George H. Kress, M.D."

* * *

(Letter dated January 19, 1938, from General Counsel Peart giving some informal opinions on questions contained in Doctor Kress's letter of January 17, 1937. Italics, etc., by the Editor)

"Re Goodall *v.* Brite—County Hospitals
San Francisco, January 19, 1938.

Dear Doctor Kress:

Upon receipt of your letter of January 17 in regard to the above case, we have reëxamined the portions of the court's opinion to which you called our attention, and have reached the following conclusions:

* * *

In regard to the determination of indigency or non-indigency, it appears to us clear, from the opinion of the District Court of Appeal in Goodall *v.* Brite, that boards of supervisors are obliged by law to determine whether or not a prospective

patient is an indigent *prior to admission* in the county hospital *unless* the case is an emergency, as defined in clause (i) of the injunction, viz.:

'A person in need of immediate hospitalization on account of accident or sudden sickness or injury or by reason of sickness or injury caused by or arising in a sudden public emergency or calamity or disaster.'

* * *

With respect to your second question, namely:

'Has a county hospital a legal right to admit an emergency patient as an indigent without first determining that point through social service investigation?'

It is my opinion that the decision in Goodall *v.* Brite conclusively determines the law to be that *boards of supervisors have no legal right to admit a non-indigent patient as an indigent without first determining the fact of indigency by 'due inquiry and investigation.'*

Whether or not due inquiry and investigation requires social service investigation is not determined by Goodall *v.* Brite, although it can be said, without hesitation, that due inquiry and investigation involves a bona fide factual inquiry by competent persons.

The reason that I have answered your inquiry in the above manner is that the injunction of the Superior Court, approved by the District Court of Appeal, specifically enjoins the supervisors of Kern County from

'Admitting to and receiving as patients of, caring for, curing or treating, boarding, nursing, furnishing food or supplies or lodging to or hospitalizing in said Kern General Hospital or at or in any out-patient clinic thereof, *any person who, after due inquiry and investigation,* is not found to be an indigent person as herein defined, or a dependent or partially independent person in case of emergency, or who is found, *after due inquiry and investigation,* to be a person who is himself, or has a relative or relatives legally liable for his support, able to pay for and obtain proper and necessary medical or surgical or hospital care. . . .'

The phrase 'after due inquiry and investigation,' which appears twice in the portion of the injunction above quoted, necessarily implies that boards of supervisors are under a duty to determine the fact of indigency or non-indigency prior to admission in the county hospital, except in those cases coming within clause (i) of the injunction, which I have previously quoted.

* * *

With respect to your next inquiry, namely:

'If a patient is entered as an indigent, by what right do they make the patient sign a note for repayment for hospitalization service later on?' it appears to me that this is a point which has not arisen in the past and, therefore, requires careful examination of all of the statutory and constitutional provisions relating to powers and duties of the several boards of supervisors.

The injunction in Goodall *v.* Brite, which was very carefully prepared and which was approved by the District Court of Appeal after a lengthy and exhaustive hearing, *leads one to believe that the District Court of Appeal assumed that persons admitted to county hospitals as indigent sick or dependent poor persons, after due inquiry and investigation had established such to be the fact, would never be called upon to pay the cost of hospitalization if they should, in the future, acquire resources, but that, on the other hand, the court definitely felt that partially indigent persons should be admitted and that such persons should be required to pay that portion of the cost of hospitalization which their available financial resources would allow.*

Of course, the *court held that persons wholly able to pay* for private hospitalization and for medical or surgical services could not, under any circumstances, be admitted to county hospitals.

* * *

It occurs to us that the situation which you mention in your inquiry could not arise if the court's decision in Goodall v. Brite is followed by the several boards of supervisors, because, if it is followed, due inquiry and investigation are made before admission. Hence, the facts are known, and only those who are partially able to pay need be required to make any payment. *If the court's decision is not followed, and no inquiry and investigation is made, the answer is, of course, that the board of supervisors must be considered to be acting in excess of its statutory authority.*

* * *

The foregoing comments are the result of a hasty reëxamination of the decision in Goodall *v.* Brite, and I am sending this to you without further research because you state in your letter that you are in a great hurry for my comment.

111 Sutter Street.

Very truly yours,

HARTLEY F. PEART."

EXHIBIT F

Presents:

1. A newspaper item of January 6, 1938, stating that the California Supreme Court had evidently found merit in the contention concerning the question, "Do county boards of supervisors have a legal right to demand liens on the property of citizens who had received county aid?"

The court's decision will be awaited with interest, because it may have an important bearing on the action of county authorities in taking liens on the property of former county hospital patients, intended to reimburse a county to cover costs of board, lodging and nursing (the usual hospitalization charges). Should not an indigent sick citizen

be as worthy of consideration as an old age pensioner, who may be in good health?

* * *

(Copy)

COUNTY FACES $960,000 LOSS IN LIEN CASE

State Supreme Court Rules 1937 Law Cancels Hold on Properties of Pensioners

Los Angeles County faces the prospect of losing $960,000 in liens on the property of 4,000 state-aid pensioners as a result of a ruling of the California Supreme Court yesterday.

The Supreme Court issued an alternative writ returnable on January 12 [1938] when Roger Jessup, chairman of the Board of Supervisors, must show cause why he should not release title to the property of eight pensioners. These pensioners accepted liens on their property in favor of the state under the 1935 law in order to obtain state aid.

Test Case

The 1937 law wiped out the necessity for such liens and was designed to cancel all former liens. The county holds 4,000 of them at a face value of $960,000. If the 1937 law is sustained, all of these must be released.

Eight recent cases of deceased pensioners were put into one suit to establish a test case, which by its action the Supreme Court agreed to hear.—*Los Angeles Examiner,* January 6, 1938.

EXHIBIT G

Presents:

1. A letter dated December 23, 1937, from the Superintendent of the Los Angeles County Hospital to the Los Angeles County Auditor, in which attention is called to faulty methods of estimating hospitalization costs, in so far as the same relate to operating rooms and personnel charges.

2. A letter dated December 27, 1937, from the Superintendent of the Los Angeles County Hospital to the Director of Accounts, Budgets and Records of Los Angeles County, calling attention to faults in the system of estimating hospitalization charges, especially as regards the use of operating rooms and personnel.

* * *

(Letter from County Hospital Superintendent to the County Auditor[22]*)*

"The Los Angeles County General Hospital,
Los Angeles, California
December 23, 1937.

Mr. H. A. Payne,
County Auditor,
Room 302, Hall of Records,
County of Los Angeles
Dear Mr. Payne:

When the cost accounting survey at the hospital was undertaken by your office and figures were finally developed as a basis for the making of charges for hospital care to patients of this institution, we were instructed as follows in connection with operating room service:

'Explanation of operating room service units: The total operating room service units per operation is obtained by multiplying the actual number of minutes spent by the patient in undergoing the operation by the number of county paid persons in attendance. The term "operating room" does not apply to surgical operations but is a general term also applicable to orthopedic and obstetrical services.'

Because this hospital is a teaching institution both for internes studying medicine and surgery and for student nurses, there are frequently in attendance in operating rooms persons in excess of the number who would ordinarily be required as a minimum necessary for the performance of the operation procedures. It might be suggested that in the determining of charges that will be entered against the patient, only those persons considered essential should be included in the cost figures maintained. In attempting to accomplish this, however, I am certain we would encounter many difficulties, for our surgeries are scheduled to be in constant use and surgical crews are changing even while the patient just operated is being removed from the table and the next patient, already under anesthesia, is being brought into the operating room. Difficulties would undoubtedly arise should we attempt to have some one individual decide just who in the operating room were essential, as so frequently the assistants considered essential could be determined only by the surgeon. At the moment that such determination should be made, there is no time allowed for 'time out' to permit the designation of certain individuals who should be present, as you will appreciate the patient is even then partially anesthetized, and as soon as he is placed on the table further anesthesia is administered and the attendants immediately busy themselves with preparing the patient for the operating procedure which is to be undertaken immediately. It is of prime importance that no delay be imposed upon or allowed the surgical staff from this moment on. Considering again that 'essential assistants' are so frequently a matter of opinion of the surgeon, it may be readily realized that two identical operations would bear different costs.

The result of following the procedure as outlined has been that charges have been made to patients who have received surgery at the hospital which are ridiculous in their amounts; in fact, it is not uncommon that charges are indicated that are considerably above those that the patient would be required to pay in a private institution. This situation is bringing a great deal of criticism to the hospital and the Department of Charities, and we must agree that in many instances the criticism is entirely justified.

To correct this situation, we strongly urge that the county charge patients for operations depending upon the average cost of performing the type of operation to be undergone by the patient to be charged. These average costs are available, and, if used, would be developed in a manner similar to the development of the costs for routine ward care. For instance, we charge a patient $4.11 per day for care in the pediatric service; $4.10 per day on the orthopedic service; $3.81 on the ear, nose and throat service, and so on through the several services. The care for which these charges are made represents the average cost to the county of providing care for patients on the respective services. It is acknowledged that between two patients on the same service, one may require and receive considerably more nursing attention than the other,

yet the charge made to these two patients is the same inasmuch as the charge is based upon the average cost of care of patients generally upon the ward in question. Could we not then consider it feasible and proper to base our charges for surgery on the average cost of performing an operation of any given character? If this could be allowed, we believe that we would be making our charges on an equitable and defensible basis and we are therefore requesting that every effort be made to authorize the hospital to prepare charges for surgical procedures on the basis suggested.

We feel that it is very important that such changes be instituted as soon as possible in order that the hospital and the county will be relieved at once of the many criticisms that have arisen from the procedures now in practice, of which we do not approve.

Very truly yours,
(Signed) Everett J. Gray,
Executive Superintendent.

cc: Supt. of Charities
Mr. Sydney Ickes
Medical Director, LACH
Medical Director, LACGH
Director, Accounts,
Budgets and Records."

* * *

[22] Comment.—At the end of six months, with an increasing number of complaints being brought to their attention, the Los Angeles County Hospital authorities finally wrote to the County Auditor and County Director of Accounts. Hospital Superintendent Gray's comment, "that charges have been made to patients who have received surgery at the hospital which are ridiculous in their amounts," does not fully tell the story. The word "ridiculous," when applied to the use of an operating room and its nursing and orderly personnel (surgical operation not included) for a cesarean section operation, and for which a charge of $136.80 was made by the County of Los Angeles, with bill sent to a supposedly indigent citizen, surely warrants words and language stronger than the benign term, "ridiculous." How can this six months' delay in rectifying what, from the outset, was nothing less than a patent error, he explained? Would the letters of December 23, 1937, and December 28, 1937, have been written had there been no complaints?

* * *

(Letter from County Hospital Superintendent to County Director of Accounts)

"The Los Angeles County General Hospital
Los Angeles, California
December 27, 1937.

Director, Accounts, Budgets and Records:

Subject: 'Billing Patients for Surgical Operations.'

Will you please arrange at once to instruct those responsible for reporting the names of employees concerned with any surgical operation that to be included in the list of those employees to be charged the patient are those individuals only who are considered essential to the operation to be undertaken. This means specifically that individuals present in surgery for the purpose of instruction, even though they may be taking part in the work to be performed, are not to be charged against the patient UNLESS they are participating in a major way.

It is essential that we correct charges immediately, for I am convinced that the rates charged to patients for certain surgical operations are unreasonable and not justifiable.

I have written a letter to the County Auditor requesting his authority to charge the patients the average cost of given types of operations, but, even before any such authorization which may be undertaken, I am directing you on my own responsibility to follow the above instructions having to do with the elimination from the list of persons whose time is to be charged patients those who are not essential to the operation.

Everett J. Gray,
Executive Superintendent.

cc: Supt. of Charities
Med. Dir., LACH
Med. Dir., LACGH."

EXHIBIT H

Presents:

A recent newspaper item of January 10, 1938, in which are given the total amounts received from former county hospital patients. Whoever gave this "publicity" to the press erred in using the words "medical care," when only room, board and nursing (hospitalization charges) could rightfully be included. The query arises as to the number of taxpayers who would be proud of sums so received by the County of Los Angeles from its indigent citizens if they knew the real story as outlined in skeleton form in these comments.

* * *

$343,489 County Hospital Fees

Reimbursements made by former patients at the General Hospital during 1937 totaled $343,498, it was announced yesterday by Rex Thomson, County Superintendent of Charities.

A record high for one month was reached last month, when former patients paid in $33,561, the report disclosed.

State laws governing county hospitals provide that each patient treated at the hospital be sent a statement of the exact cost of the medical care administered. The patient is required to pay the hospital when financially able.

County hospitals cannot accept for medical care any person able to pay for such care at a private hospital, unless an emergency exists, according to the statute, Thomson said.—*Los Angeles Times,* January 10, 1938.

EXHIBIT I

Presents:

1. A somewhat pertinent item from a San Luis Obispo County newspaper of December 16, 1937, on an action taken by the attending staff of that county's public hospital.

2. A copy of the letter sent to the Board of Supervisors of San Luis Obispo County, stating why the attending staff took the action noted.

* * *

(Copy)

POLITICAL MANAGEMENT INTOLERABLE, IS CHARGE

All physicians, surgeons, and dentists in San Luis Obispo have withdrawn from any connection with the General Hospital, until changes in the administration are made by the board of supervisors.

The doctors and dentists, in a letter signed by every member of the county medical and the dental associations, and delivered to the county clerk on Thursday morning, resigned from the visiting staff of the hospital.

Complete lack of coöperation between the supervisors and the visiting staff was given as the reason for the resignation. The county board is charged with refusing to act on the suggestions and recommendations of the staff.

The staff is composed of all the doctors and dentists residing in the county, and the work of supervising and assisting in the hospital activities is rotated among them.

Give Reason

Discussing the reasons behind the resignation, the physicians said:

"We have a county hospital which represents an investment of approximately $350,000, and a fine institution. The county medical association organized a visiting staff and tried to operate it as a high-class institution. We have had a rotating staff, changing each three months and working with the county and resident physicians at the hospital, with the hospital doctors under our supervision. All this work has been given gratis by the doctors and dentists of the county.

"In six years of constant effort we have tried to get the hospital as approved and we secured this approval only a few months ago, putting the hospital on a par with the best in the country.

No Coöperation

"But we have been having increasing difficulty in getting coöperation from the board of supervisors, especially in the past few months. We have been trying to get the supervisors to let the doctors of the county assume complete control of the institution, including supervision, and the direction of the county and resident physicians.

"We also are asking for a separate welfare department for the hospital. We believe the people know that there are many patients admitted to the hospital who have no business there, no matter what their income or what might be their ability to pay for hospitalization or medical and treatment costs. This is unfair to the taxpayers who have to pay for the cost of taking care of these people.

"The board of supervisors has completely ignored this situation, and the doctors feel that the hospital has become a political football, with anyone securing an order from a supervisor entering the institution, without regard to the right or need of the patient, to have such free service.

"Twice in the past three months the supervisors, without asking the advice or opinion of the visiting staff, have appointed doctors who have not been admitted to the practice of medicine in California. It was necessary for the State Board of Health to send down representatives to tell the doctors to stop practicing or go to jail, which stopped their continued duties at the hospital.

Work Harmoniously

"Between the doctors of the county, the county and resident physicians and the nursing staff and employees of the hospital, there always has been close coöperation, and patients have been properly cared for.

"It is the unanimous opinion of the medical and dental societies of the county that they can no longer work with the hospital so long as the supervisors continue their present attitude.

"The situation has been growing worse for the past year and a half, and the doctors and dentists of the county want no part in the hospital as it now is being conducted by the board of supervisors."

It was explained that the request for a separate welfare department for hospital cases was needed so that investigation of the ability to pay of patients might be established, so that only really indigent cases, for which the hospital is operated, and the only type of patients admissible under a Supreme Court ruling, would become patients, while those who can pay should go to private hospitals.—*San Luis Obispo Press*, December 16, 1938.

* * *

TEXT OF DOCTORS' LETTER

(Copy)

San Luis Obispo, California
December 14, 1937

Board of Supervisors
County of San Luis Obispo
San Luis Obispo, California

Gentlemen:

Since the establishment of the San Luis Obispo County General Hospital the physicians and surgeons and dentists of the county have organized and maintained an active visiting staff at the hospital. Through their efforts and with the kind coöperation of the nursing staff, the professional standards of the institution have been raised to the point where indigent patients have been receiving professional and nursing care favorably comparable to that received in any public or private hospital. This fact is attested by the recent recognition given our hospital by the American College of Surgeons when they placed it on their approved list of hospitals. This means that the hospital has successfully met the high standards required by that organization throughout the country.

Several months ago we called your attention to the fact that certain methods of operation in connection with the San Luis Obispo County Hospitals were unsatisfactory. We suggested a possible remedy. Nothing has been done to correct the situation. We feel that under the present political management of the hospital, conditions are intolerable. Therefore, the visiting staff of the hospital, in regular meeting assembled, December 7, 1937, unanimously resigned from active service at the hospital, effective immediately.

We wish to remind you that since the establishment of the hospital we have given freely of our services without remuneration—and we might add without the slightest token of thanks or appreciation from your body. We wish also to remind you that throughout the history of the institution there has been a complete absence of friction between all members of the working staff of the hospital. We still stand ready to give our services to the County Hospital, provided that institution is operated for genuinely indigent patients and free from political influence. It is our feeling that this can be accomplished only by giving the visiting staff full control of the scientific operation of the hospital and by the establishment of a social service department at the hospital responsible to us, and to nobody else.

Yours very truly,
(Signed): E. D. ANDERSON,
Secretary, Visiting Staff, San Luis Obispo General Hospital.

* * *

[Comment.]—This concludes the series of exhibits, presented in connection with editorial comment, in this February issue of the OFFICIAL JOURNAL of the California Medical Association. What has been given above presumably only deals with the surface of the principles and facts involved. Every county medical society, through its committee on hospitals, and constituted authorities, should know what is going on in its own county hospital; and any procedures and methods seemingly at variance with the law of the State should be promptly reported to the central office of the Association. The members of the Los Angeles County Medical Association certainly should take an interest in the unusual innovations recently instituted in their own county hospital.

727 Roosevelt Building.

THE LURE OF MEDICAL HISTORY†

ROBERT ARMISTEAD McLEAN*

CALIFORNIA'S FIRST MASTER SURGEON

IV

By Robert T. Legge, M.D.
Berkeley

THE world was startled when, in 1849, gold was discovered in California; and many adventurous gold seekers rounded the Horn that year. Among these were Dr. Samuel Merryweather McLean and his wife, Ellen Grey Jeter McLean, both natives of Virginia. This pioneer physician was attracted to the Mother Lode Country, and was finally located in Stockton, where he built the first hospital and the second frame house. Doctor McLean was a busy worker in the hospital. As early as 1852 it was crowded with smallpox patients, victims of a raging epidemic then in progress. The Odd Fellows, of which the doctor was a member, have chronicled that he was one of the most sympathetic and generous of men. In the frame house on January 6, 1851, was born Robert Armistead McLean, the first white child of Stockton, destined to become California's first master surgeon.

DAYS OF YOUTH

Young Robert received his early education at the family fireside and at the little school of the small town. In 1860 his mother took him on a visit to her brother's plantation at Point Coopée, Mississippi. At the outbreak of the Civil War she was, fortunately, able to get through the lines by way of Nashville, and so to reach Bethlehem, Pennsylvania. There she remained with another brother, John Tinsley, until 1863, when she and her daughter, Mary, returned to California, leaving Robert at Doctor Schwartz's Bethlehem Academy. While at Bethlehem he taught a Sunday-school class at the Church of the Nativity. In 1866 he returned to the family home, then at Copperopolis, California. At the age of eighteen he became an apprentice in the study of medicine under his father.

In a letter to Uncle Jeter, dated from Tuolumne City, July 27, 1870, he relates that he was teaching in the district school, though apparently disliking it. His ambition was to go to the California University as soon as circumstances would permit. Discouraged because of the failure of crops and the meagerness of his father's practice, Robert was, nevertheless, hopeful that, by saving $50 of his $75 a month salary as teacher, he would be able to accumulate sufficient money to support himself for one year.

AN INTERESTING STORY

There is a story to the effect that the celebrated Dr. Hugh Huger Toland of San Francisco, founder, in 1866, of Toland Medical College which, in 1872, became the medical department of the University of California, had some difficulties with a fellow who menaced his life. Through the efforts of Dr. Samuel M. McLean, who befriended Doctor Toland and who succeeded in getting him out of these embarrassing difficulties, was developed a mutual friendship which made it possible for the elder McLean to request a great favor of Doctor Toland, namely, that he should become the preceptor of his son, Robert. He was thus accepted, and began to take lectures at the college.

TOLAND MEDICAL COLLEGE

Doctor Toland was professor of surgery and taught in the college he founded, which was described in an announcement of the time as "a massive brick and stone edifice, one of the most complete and stately medical colleges in the country." The college had a museum that contained an extensive collection of specimens and preparations, a dissecting room fitted with all the modern improvements, and a laboratory replete with all the chemicals and apparatus necessary for practical teaching.

MEDICAL STUDENT DAYS

It was here that the talented Robert A. McLean labored as a student in medicine. His early student days were those of a continuous struggle for existence: he acted as janitor and even slept in the college building; later he lived in the office of Doctor Toland, who occasionally gave him a few dollars for food. He said that he was often actually hungry. As a student he became keenly interested in the study of human anatomy, and mastered it. While at college he acted as preceptor and later as demonstrator of anatomy.

At the commencement exercises in 1874 he was graduated—the first native son to receive the degree of Doctor of Medicine.

TEACHER AND DEAN

It followed that the graduate became a member of the faculty as lecturer in anatomy and as secretary to the dean, Dr. R. Beverly Cole. During this period, he also continued his association with Doctor Toland, whom he assisted in his private practice and in his duties as professor of surgery at the county hospital. This afforded the young doctor the opportunity of his life to become a surgeon. In the meantime he was elevated to the position of professor of anatomy. Then he succeeded to the chair of clinical and operative surgery when Doctor Toland died in 1880. He held this professorship until his retirement. Doctor Toland, in his will, bequeathed "to the most competent man to succeed me, my office, furniture, instruments, library, and practice." The office, located at 603 Merchant Street, corner of Montgomery Street, was where Doctor McLean commanded the largest surgical practice in California until 1897 when, at the height of his activity, he was stricken with hemiplegia. From 1881 until

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

This is Paper IV of the series. For other articles in the symposium, see California and Western Medicine, November, 1937, page 321; December, page 405; January, page 27.

1899 he was also dean of the college, finally being succeeded by Dr. A. A. D'Ancona. What an abundant life was crowded into these eighteen successful years!

MC LEAN FAMILY

Doctor McLean's sister, Bessie, was married to one of his honor students, Dr. C. W. Evans of Modesto, of the class of 1881. They became the parents of Dr. Herbert McLean Evans, the distinguished scientist of our University of California. About this same time, in June, 1881, Miss Alice May Thompson, a native daughter from Benicia, became the wife of Dr. Robert A. McLean. She bore him three sons, Robert A. Jr., Tinsley, and Arthur T. McLean. A cherished ambition of Doctor McLean was to have one of his sons follow his footsteps in the study of medicine; the failure of one or the other of them to do so was a great disappointment to him.

MEDICAL CATALOGUE ANNOUNCEMENTS OF 1880

A review of some of the printed announcements of the time, concerning Doctor McLean's professorship in surgery in 1880, will give an idea of the high quality of practical and scientific instruction that he instituted for the medical students in the "Far West" of three score years ago:

"Surgery.—Instruction in this department will embrace: First, a regular course of lectures on the principles and practice of surgery; second, demonstrative surgery upon the cadaver; and third, a thoroughly clinical course, including diseases of the genito-urinary apparatus, at the City and County Hospital and College Building."

"Didactic Teaching in Surgery.—Professor McLean delivers three lectures each week on the art and science of surgery. The most recent views of the management of surgical conditions and the appliances devised for their relief are particularly dwelt upon, and illustrated with drawings and models, when necessary. This course will include a series of lectures upon operative surgery, with demonstrations on the cadaver. The student will be drilled in the manipulation of instruments used in the various operations."

"Minor Surgery.—Professor McLean conducts a course of minor surgery during the preliminary term. Instruction in this branch includes the application of bandages and various dressings used in treating wounds, fractures, dislocations, etc."

MASTER SURGEON

Some years ago, in a personal conversation, Dr. Emmet Rixford, then professor of surgery at Cooper College, speaking of Doctor McLean, remarked that he was truly California's master surgeon, an ethical man whose professional advice was sought by his colleagues. He had great native ability, acquired only through his own studious endeavors, never through observations or experience gained in the great hospitals and schools abroad. He was never able to take time off for any foreign travel. Dr. Emma Sutro Merritt, one of his students graduating with the class of 1881, San Francisco's first woman surgeon, who also received a medical degree from the University of Paris after five years of study in Europe, commenting on Doctor McLean, stated that he was a greater surgeon than any of the reputed surgeons she had seen abroad. "He lived," she said, "in the wrong part of the country; his place should have been in the world's largest metropolis."



ROBERT A. McLEAN, M.D.
1851–1914

AN IN MEMORIAM TRIBUTE

Dr. Rawlins Cadwallader of San Francisco published an article entitled, "In Memoriam," in the *Compend of Medicine and Surgery* for November, 1928. In this article he paid tribute to his old chief. I quote a paragraph which speaks of the period subsequent to his stroke:

McLean was of the old school of surgery. He had his training in pre-aseptic days and was one of the few such men who grasped the significance of, and consistently followed, asepsis. His operative dexterity was a marvel. I have seen Murphy, Bull, Senn, Halstead, Keen, Horsley, Kocher—the world's most celebrated operators—and I assert positively that none of them even approximated McLean as an operator. He was by all odds the most rapid and dexterous operative surgeon the world has ever seen. To see him work did not impress one with the fact that he was fast, but it was an exhibition of precision. Not a movement lost, not a motion but had its place. He never snapped but once for an artery, never hesitated over anatomy, never changed sides until half-done, and tied his knots almost faster than the eye could follow his hands.

He was an absolute master of anatomy, and once remarked that it was like letters to one who could read. When one was a surgeon, he did not need to think of his anatomy."

AUTHOR'S RECOLLECTIONS OF DOCTOR MC LEAN

To reminisce: My own student days as an upper classman were near the end of Doctor McLean's clinical teaching career at the old surgical amphitheater of the City and County Hospital in the years 1897-1898 and 1898-1899. In my memory, like a picture, still lingers the impression of the time when I was first introduced to operative surgery and to Doctor McLean—impressions of a tall, lanky, dark-complexioned man, with black hair and a close-trimmed beard. He reminded me of a great

genius of the Lincoln type and character as he stood in the arena, dressed in his immaculate street trousers and polished shoes, a short white coat over his vest, his long ungloved hands and fingers washed and treated with bichlorid, and calling out to the senior who was assigned to the chloroformed patient on the table, "Whose case is this?"

He expected a complete history, a diagnosis, method of surgical treatment, and a knowledge of applied anatomy. He would demand reasons for the students' diagnoses, present arguments, ask for proofs, challenge their validity, all with the purpose of clarifying and crystallizing the picture in their minds, training their interpretive and diagnostic judgment. These quizzes in differential clinical diagnosis and surgical anatomy were an experience in inspired teaching. As professor of clinical surgery, perfect anatomist, remarkable diagnostician, endowed with marvelous judgment and precision, this great genius possessed all the attributes of perfection in his field. Remember, too, that those were the days of antisepsis, before the advent of modern asepsis and the roentgen ray. Laboratory procedures were comparatively primitive and chloroform was the main anesthetic.

With a few master strokes of the scalpel, with unparalleled speed in a field that was practically bloodless, with a superb technique original in many of his operations, he exhibited the work of a great master. To witness a complete hip-joint amputation; the femoral artery severed and caught instantly with a forceps, stitched, dressed and completed in twenty-eight minutes, was an experience never to be forgotten. He regarded it as unpardonable if a drop of blood stained his coat or appeared above the knuckles. His surgical nurse at the County Hospital, Miss Kane, who could read his mind, and who knew always and instinctively what instrument or ligature was required—for when he thrust his right hand backward toward her table, the desired article was at hand—must be remembered with respect and admiration.

HOSPITAL ROUNDS

What a treat it was to make the rounds with him and to watch him examine a patient and notice his careful and watchful survey of the field where pathology was present. It seemed that the very ends of his fingers possessed eyes, so acute was the tactile sense and his ability to interpret what he felt and observed.

In the wards, where there were always many fracture cases, the present-day orthopedist would marvel at the dexterity of this great and skillful surgeon in diagnosing and reducing a fracture and achieving such astonishing results. In his male surgical ward, consisting of thirty-two beds, was a male nurse named O'Connor, who was trained by the chief as a dresser, and whose knowledge of traumatic surgery was unusual. It was really unbelievable to see this remarkable man reduce complicated fractures and dislocations. Doctor McLean seldom disturbed, after examining, O'Connor's "cases." Woe to the intern or poor senior student, however, who, upon being questioned as to the diagnosis of such a case, should reply that O'Connor had made the diagnosis!

I believe that it was during the time that the American Medical Association met in San Francisco that a surgical clinic was held to demonstrate a new operation for vaginal hysterectomy. Three cases were to be operated upon: one by a celebrated New York gynecologist, the second by the great Philadelphia surgeon, Dr. W. W. Keen, and the third by the apparently unknown Robert A. McLean. Doctor McLean surprised everyone present by performing the operation in half of the record time.

We students remember his dry humor during the clinic hours at the County Hospital. A usual remark to a patient who had some minor abscess that did not warrant a general anesthetic was, "What nationality are you?" If the answer were "Irish," Doctor McLean would play up the bravery of this race; the patient would respond, and before he had time to think the abscess would be incised.

He employed another ruse in respect to malingerers occupying "political" free beds who claimed, for instance, that they had sciatica or backache. After Doctor McLean had examined the patient, with pseudoseriousness he would turn to the intern and say, "Doctor, this poor man can be cured by singeing along the spine with a red-hot iron. Have it ready tomorrow morning." If the patient were a genuine malingerer, the bed would be empty at the appointed hour.

DOCTOR MCLEAN AS DEAN

In his position as dean of the college, Doctor McLean gave the impression of austere unemotionalism, which belied his true nature. Perhaps this was due to the great responsibilities he carried both in his private and in his public practice. But those really acquainted with him knew that he would do anything within his power for his poor patients, especially for the members of his beloved profession. Many practicing physicians owe their starts to Dean McLean. Many a promising young student, unable to continue his medical training because of financial inability, was aided by this kind man, who advanced the funds and charged them to his own private account. His whole interest was in higher medical education and in the welfare of medical students.

His duties as dean of the college, professor of clinical surgery, and his lucrative practice demanded much of his time and effort. Nevertheless, he never missed his classes or County Hospital clinics; he was punctual to the minute. Those were the horse-and-buggy days, when he kept two teams always in readiness to enable him to attend to his large practice and hospital work.

Doctor McLean's real respect for members of the regular profession was characteristic. He was punctiliously ethical in all his relationships, particularly in the education of medical students, and to his patients. Notwithstanding his busy professional life, he spent many hours in reading the classics and great books. He was familiar with the current medical literature, enjoyed the drama, and

was a patron of grand opera. It was his especial joy to read aloud to his wife and boys. His priceless collection of books was lost in the great fire of 1906.

MACLEAN CLAN

At his home on Pacific Heights he was fond of receiving his colleagues in the medical profession, distinguished visiting notables and faculty members from Berkeley. He enjoyed displaying the McLean plaid to visitors, and was proud of the fact that, while attending the Columbian Exposition at Chicago in 1893, he had met Sir Le Roy Donald Maclean, chief of his clan of the Isle of Mull.

Doctor McLean held memberships in the medical societies of California, but seldom, if ever, attended the meetings. In the line of social organizations he was affiliated with the Sons of the American Revolution, the University of California Club, and Family and Caledonian clubs of San Francisco. He was a man of deep religious convictions, by faith an Episcopalian. A student of the Bible, he was able to repeat whole chapters from memory. During the last years of his life, he attended St. Mark's Episcopal Church in Berkeley, where Bishop Parsons was rector.

EARLY MEDICAL JOURNALS OF CALIFORNIA

Among the early medical journals published in San Francisco was the *Western Lancet,* which appeared in 1872. This periodical, before its merger with the *Pacific Medical and Surgical Journal* in 1884, was practically the official organ of the Toland College faculty. Doctor Toland published therein many of his case reports and accounts of his surgical operations and procedures. Many of these Doctor McLean collected and edited. However, it was this editing that discouraged McLean as to the value of publishing papers; he wrote very few during his life. At Doctor Toland's demise, his brilliant associate succeeded him, to become the foremost surgical practitioner on the Coast. In spite of the many daring and original surgical operations that he performed, he left few published contributions for posterity.

In the *Western Lancet,* December, 1880, there appeared, under "Original Communications," a valedictory address by Doctor McLean, delivered on behalf of the faculty at the annual commencement, November 10, 1880. After the usual advice given to the young graduate—as to his relations to patients and to the profession—he admonished quacks and nostrums of the day. He exalted the regular profession and the health officers in checking a plague that was at that moment prevailing. Then he made a plea for a general State Hospital for all indigent sick—to be located in the commercial capital and largest city, San Francisco. Concluding his address was a eulogy paid to Professor Toland, whose perfect character he held up as a lofty model for the contemplation of the young doctor.

CONTRIBUTIONS TO THE LITERATURE

His special interests apparently were centered in malignancy and tuberculosis. Upon these subjects three papers were published:

"The necessity of Early Surgical Interference in Malignant Growths," *Journal of the American Medical Association,* 1894.

"Cancer of the Rectum," *Transactions of the Medical Society of California,* 1895.

"The Superiority of Amputation Over So-Called Conservative Methods of Treatment of Tubercular Disease, Injury and Malformation of the Lower Extremities, *Pacific Medical Journal,* 1895.

He also wrote a manuscript for the *Cyclopedia of American Surgeons* on Hugh H. Toland, a copy of which is now preserved in the Crummer Library of the University of California Medical School, the gift of Professor Howard Naffziger.

It is said that McLean devised an original operation for cleft palate, for which a special instrument was invented. His interest in young men's leading clean and industrious lives caused him to publish, in 1908, a small monograph, *Letters of Advice to a Young Man.*

RETIREMENT FROM CLINICAL TEACHING

In 1898 Doctor McLean found himself so broken in health that he finally gave up his clinical teaching at the County Hospital. He was succeeded by Dr. Charles Brigham of San Francisco and later by Dr. Thomas Huntington of Sacramento. He became emeritus professor of clinical surgery in 1903, an honor which he held until his death. On May 10, 1899, the secretary of the faculty wrote Doctor McLean:

"At the last regular meeting of the faculty, your resignation as dean of the department was with much regret accepted. It was resolved that the thanks of the Faculty be extended to you for your long and valuable services, with profound esteem and respect felt for you personally, and their appreciation of your efforts in building up the College."

HIS FAMILY LIFE

During the next twenty years of his life, his professional activities curtailed and his beloved teaching finished, Doctor McLean felt deserted and saddened. His loneliness was augmented by the loss of his wife, in 1897. He has written of her: "When Alice was alive she went to the market herself every morning; and brought home such articles as she could conveniently carry in a basket. She had a keen sense of humor, a rare quality in feminine nature, and the sweetest, most amiable disposition of any human being I ever knew. She would act out the drama that she had seen performed, for the benefit of me, when the pressure of a large practice had prevented my attendance at the theater." The sweetest romance of Doctor McLean's life is the charming and lovely story of his meeting with Alice, in 1880, when he was on a professional visit in the town of Benicia, California. This distinguished young San Francisco surgeon was dining in one of the restaurants of the town. At another table there was a young lady, a student in attendance at St. Mary's Hall. Doctor McLean was so attracted to the demure, quiet, small and lovely young woman of nineteen that he

pressed one of the attendants to arrange for an introduction. It was love at first sight; and a short while afterward "Sweet Alice" was to be Mrs. Robert A. McLean.

TOLAND MEDICAL CLUB

Responsive to the invitation of R. A. McLean, an interesting meeting of the University of California Club took place on November 20, 1914. Those present were E. D. Martineaut, '73; William H. Mays, '73; J. R. Davidson and R. A. McLean, '74. The purpose of this gathering was to organize a club, consisting of the earlier members of his college associates. Doctor Martineaut was elected president and Doctor McLean, secretary. The club was for social purposes only. In order to discourage all scientific discussion and to foster good fellowship and a spirit of fraternity, the chairman, always the oldest graduate, was to condemn anyone starting a like discussion to the execution of such penalties as singing a song or making a speech. This Toland Medical Club was to be modelled after the immortal "Pickwick Club" of Dickens. The minutes of this first meeting are to be presented to the Crummer Library archives.

RETIREMENT DAYS

During Doctor McLean's retirement period he took his first voyage to Europe. While visiting Glasgow he consulted the then famous surgeon, Sir William McEwen, who diagnosed his case as a gliomatous tumor and advised an operation, declined by McLean. (Doctor McLean's early retirement was due to unilateral ataxia, due to the old hemiplegia). His surviving sister, Mary Ellen McLean, during his absence supervised his home and cared for his three growing sons. This pioneer woman died at Berkeley on April 1, 1937, at the age of eighty-five.

SUBSEQUENT YEARS

After the earthquake in 1906 and until 1915, McLean occupied an office with one of his old colleagues, Dr. George H. Powers. At this office, at the corner of Ellis and Powell streets, he enjoyed quite a little practice among old friends and charity patients. His good friend and office nurse, Miss Ann Sullivan, assisted him in his work. She relates that the number of types of minor office surgery he performed was surprising.

In the last days of his retirement he resided at Cloyne Court, in Berkeley. On December 4, 1918, he succumbed at Alta Bates Hospital as a result of influenza and pneumonia. The funeral took place at the home of his nephew, Dr. Herbert McLean Evans. After an Episcopal service, he was laid to rest in the Iona Churchyard at Cypress Lawn Cemetery in San Mateo County. Two of his former students, Dr. Wallace Terry and the writer, acted as pall bearers. On his gravestone is the Crest of the Clan McLean with its motto, "Altera Merces." How beautiful and appropriate were the translated words, "Another Reward," as the curtain was finally drawn in the passing of the foremost pioneer master surgeon of California.

University of California Medical School.

THE PASSING OF PROFESSOR GEORGE H. F. NUTTALL

By Douglass W. Montgomery, M.D.
San Francisco

A SHORT notice in the daily papers has notified us of the demise of Dr. George Henry Falkiner Nuttall, professor of biology, Cambridge, England. Doctor Nuttall was a remarkable man in his own right, but he had a special interest for us in San Francisco, for he was of our city; and in 1886, when I came here, he was slated for the chair of pathology in the Toland Medical College, then loosely connected with the University of California. His notable work on the blood, however, secured for him such recognition that he was called to Cambridge.

Doctor Nuttall's father practiced medicine for many years in San Francisco, in association with Doctor Mackintosh, in offices on Post Street, just west of where now is the Mechanic's Library. Their chief work was obstetrics and, as Dr. David Cohn once told me, they delivered almost every woman in this city in their day, or rather night, and if anyone wishes to learn how dexterous Mackintosh was in handling the forceps, let him consult Dr. George F. Shiels. They say that Nuttall was equally expert. When Robert Kennedy Nuttall and Dr. Robert Mackintosh were in full practice, obstetrics was, as Cohn also informed me, very lucrative. Consequently Nuttall, who had married into the Parrott family, became quite comfortably situated.

Mackintosh was not so fortunate. He was incorrigibly careless in his financial habits, and by the time I came here his practice had dwindled, as practices have the habit of doing. He lived as a bachelor, and had a modest office far out on Mission Street. There was, however, no doubt of the grandeur of the man with his noble features and flowing white beard, sitting erect while driving his horse and buggy. "A man's a man for a' that," was written in his every lineament.

Because he was supposed to have Bright's disease, Nuttall retired from practice in 1865—a grave resolution. In that day albuminuria and a few hyalin casts portended early death, whereas albuminuria occurs to many a man in good health, and a few hyalin casts carry with them, as Osler once said, a guarantee of a long life. I had a brother-in-law who, in his youth, was condemned to a year in bed on the same evidence, and he lived to be past seventy.

Doctor Nuttall's father traveled about Europe for eight years. As Victor Hugo once said, there are two kinds of hell: one in which you are tormented, and one in which you are bored, and the latter is the worse. After walking through picture galleries, and conversing mostly in monosyllables with waiters and cab drivers, Nuttall returned to San Francisco and resumed connection with his old friend, Mackintosh. He terminated this life in 1881, sixteen years after the above-mentioned grave diagnosis, and then only through inadvertence, for he went fishing with his friend, Mackintosh.

As I understand it, it was the grandfather of our Dr. George H. F. Nuttall who was the Nuttall of Kew Gardens, after whom so many plants are designated as "Nuttallii." His sister was the late Azalea Nuttall, the well-known antiquarian, so learned in the history of Old Mexico.

With such a family history, that George H. F. Nuttall should have attained prominence in the development of modern medicine was, therefore, no accident.

450 Sutter Street.

CLINICAL NOTES AND CASE REPORTS

THE PROCTOVACUATOR

By Chelsea Eaton, M.D.
Oakland

THE successful proctoscopic examination, like the successful surgical procedure, depends upon good exposure. Many of the attempts to perform a satisfactory proctoscopic examination are frustrated by feces which block the advance of the instrument. Unfortunately, the "careful preparation" of the lower bowel by enemata is frequently inadequate, and the attempts to remove the detritus by suction tube and swabs are of little avail.

Obviously, the purpose of the proctoscopy is defeated by any method which is not concerned with obtaining a clean bowel as a preliminary to examination.

For example, the use of the 15-centimeter proctoscope, instead of the 25-centimeter instrument, provides increased facility of instrumentation and may partially obviate the necessity of obtaining a clean bowel. However, there is proportionate devaluation of the findings because of shorter tube employed. Again, the practice of passing the proctoscope, with obturator inserted, through masses of feces which confront the advancing tube can afford little satisfaction to the examiner because of fields which have not been visualized.

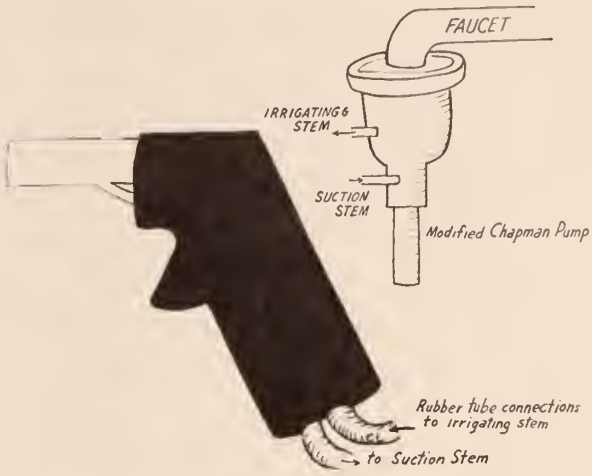


Fig. 3.—Showing tube connections of proctovacuator and pump.

The desideratum is a clean bowel. A suction apparatus is patently insufficient because of fecal blocking. A device that will provide alternate irrigation and suction through a single tube will not only keep the lumen free, but will provide a hydraulic stream which will disintegrate fecal masses and facilitate their removal by the suction apparatus.

The instrument described herein combines the factors of suction and irrigation in reciprocal relationship. Thus, while the trigger is at rest, a stream of water is sent through the barrel and the fecal masses are disintegrated. Conversely, when the trigger is pressed, the irrigating stream is interrupted and the bowel contents are evacuated. A rapid, alternating process of irrigation and evacuation enables the operator to obtain a clean field for inspection, and permits him to advance the proctoscope to its full extent. Barrels of various lengths may be interchanged according to the length of the proctoscope used. The instrument is readily cleaned by operating it while the barrel is inserted into a cleaning solution. A Chapman pump, which

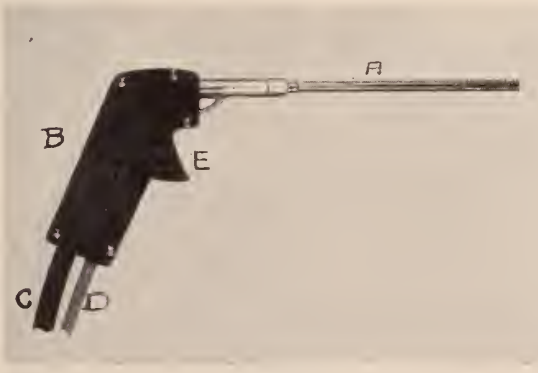


Fig. 1

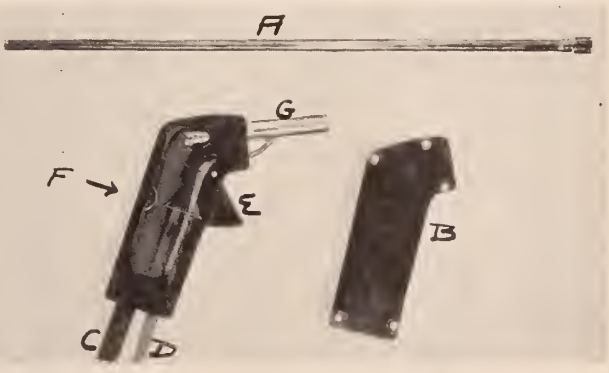


Fig. 2

Fig. 1.—Showing proctovacuator assembled. A, detachable barrel. B, bakelite pistol grip. C, suction tube. D, irrigation tube. E, trigger control.

Fig. 2.—Proctovacuator mechanism. The right half (B) of the bakelite pistol grip has been removed to illustrate the trigger mechanism (F). While trigger (E) is at rest as shown, the irrigating tube (D) is compressed by strips of tempered metal which surround it. In this position, also, the suction tube (C) is open. However, when the trigger is pressed the action is reversed in each tube because the strips surrounding the irrigation tube (D) are forced apart and the strips surrounding the suction tube (C) are forced together. (G) metal chamber which connects rubber tubes to barrel.

contains an outlet stem above the suction stem, is used as a combined source of suction and irrigation.

SUMMARY

Some common obstacles to the performance of proctoscopy have been pointed out, and an instrument described by which these may be overcome.

Medical Center Building.

SQUAMOUS EPITHELIAL BONE CYST OF THE TERMINAL PHALANX*

By William W. Reich, M.D.
Berkeley

THIS report is prompted by the recent article by Bissell and Brunschwig.[1] These authors, after presenting a short review of the literature, add two new cases. They also call attention to the probable rôle of trauma in the genesis of the pathologic lesion.

REPORT OF CASE

A German female, aet. forty-three, complained of a tense, painful and tender spot near the tip of her right first finger. She stated that this "sore spot" had been noted for about six months, but that she had absolutely no recollection of having injured the finger in any way. About two weeks previously, a doctor had incised the tip of the finger and she stated that this eased the tension. Her past and family histories presented no relevant data. Examination revealed a very tense, slightly reddened, moderately tender finger. A small zone on the inner border appeared fluctuant. The base of the nail seemed slightly raised. X-ray examination, April 7, 1937, presented the rather striking findings shown in Figure 1. The radiologic diagnosis was chronic osteomyelitis; however, bone cyst, chondroma or other neoplastic process were suggested as possibilities. On April 18, 1937, under local anesthesia, the overlying soft tissues were incised and the underlying bone thoroughly curetted. A fairly well-defined, whitish, membranous shell measuring about 2 by 3 millimeters was scooped out in the process. A small wick was placed in the wound and moist dressings applied. The wound healed rapidly by first intention. No suppuration was encountered either at the time of operation or subsequently. X-rays, taken on May 25, 1937, are shown in Figure 2. It is apparent that very little filling in had taken place, except for the small deposit about the cyst edges. Histological examination of the small shred obtained at operation revealed the wall of a bone cyst lined by typical stratified squamous epithelium. Figures 3 and 4 show, respectively, low- and high-power magnifications.

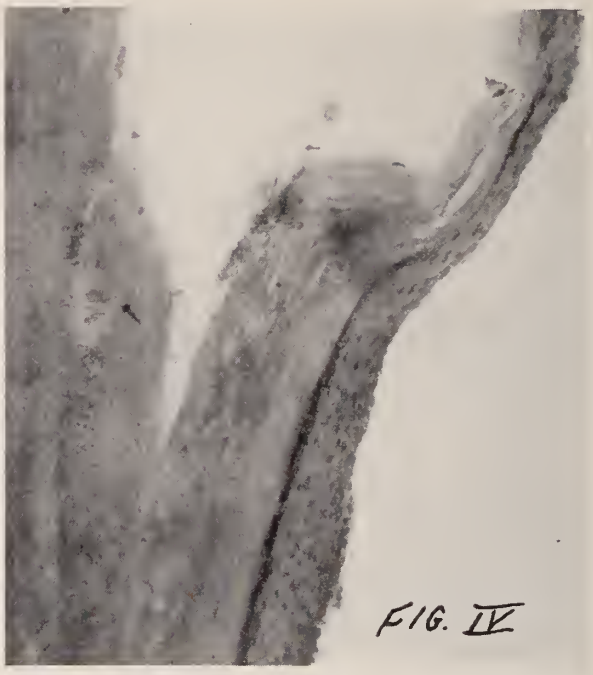


Fig. 4.—Stratified squamous epithelium lining cyst as seen under high powers of the microscope.

In the article quoted above, a discussion of the theories of the origin of these interesting structures is presented. The trauma theory probably explains most cases; however, in some instances, as in the present case, no history of injury could be obtained. It appears that diagnosis must rest upon pathologic examination of curettings, since confusion with other lesions cannot be eliminated by gross examination or radiologic studies.

2236 Durant Avenue.

* I wish to thank Dr. R. D. Joldersma for the opportunity of seeing this patient.

1 Bissell, A. D., and Brunschwig, A.: Squamous Epithelial Bone Cysts of the Terminal Phalanx, J. A. M. A., 108:1702, 1937.



Fig. 1.—Bone cyst; radiogram before operation.



Fig. 2.—Bone cyst after operation; note beginning filling of cyst cavity.

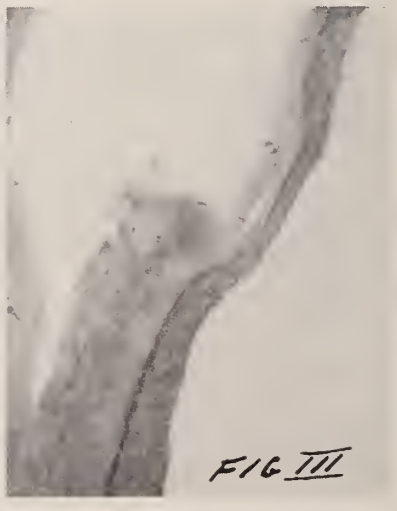


Fig. 3.—Low power appearance of section of cyst wall.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

INSOMNIA

I. ETIOLOGY

Lovell Langstroth, M.D. (516 Sutter Street, San Francisco).—If one questions a patient with insomnia as to why he or she cannot sleep, the answer invariably will be, "Because I cannot stop thinking." And this seems to be the fact. These patients cannot sleep because they have a compulsion to thought. This state may be brought about in a perfectly normal person by some unusual event; a disappointment in love, the death of some member of his immediate family, business reversals, or physical disease. But these normal persons recover from their physical disease or adjust to the new conditions in a reasonable time, and soon sleep as well as before, while the persons under discussion present no physical disease, have nothing serious to worry about, and still are permanently unable to sleep satisfactorily. In them the disturbance of function is traceable to an inner, rather than to an outer cause, and must be treated along psychological lines if it is to be permanently overcome. For drug therapy is not only unsatisfactory to the patient himself, but finally fails to give him the rest he craves. Discussing the etiology of insomnia, then, really means discussing the etiology of this compulsion to thought; and what I shall attempt here is to sketch in briefest outline the psychological processes which force these persons against their will to awake nights and "think."

An analysis of this process shows that the conscious will of the patient to sleep is opposed by this compulsion to thought, or by an opposing will, so that we find here two opposing will forces. The greatest light has been thrown on these will forces by Otto Rank,[1] who speaks of them as the positive and negative will. But to understand what is meant by these terms it will be necessary to review briefly the development of the will as he has sketched it in the individual.

We must remember, in this connection, that the individual was once a part of the mother from whom he sprang, and that in infancy at least, he always yearns for her and resents separation from her.[2] This state of affairs forms the basis for the development of two elemental forces in the individual, one of which we may call positive and the other negative. At or about puberty these more primitive urges become partly differentiated into the positive and negative will, that is to say they become more conscious and subject to control. The average person, then, takes on the pattern he is to follow during the remainder of his life: he projects his opposing will onto some outer authority (parent, social will, government), and, now that he has delegated the job of restraining him to someone else, feels free to accept and express his positive will, and with it the racial sexual compulsion, or the positive primitive urge.

But there are certain strong-willed persons who differ fundamentally from the average in their inheritance and development. From birth on they have a stronger desire for union with the mother, and when separation from her is forced, resent it more: they hate the mother for causing them this pain. They also react in an exaggerated way to the pain of this separation, that is to say, instead of accepting it they deny the desire and its object altogether so as to save themselves pain. This is as much as to say: "I do not care, I did not want it anyway." The average person denies desire, too, but only until the intensity of the pain of separation has diminished, while these strong-willed persons continue the denial indefinitely. This does not change the true state of affairs, of course: the strong desire and hatred are still there below the surface. Later on these more primitive forces differentiate into will forces, but the denial is carried over into the realm of the will, prevents the individual from coming into positive affective relation with the object, *i. e.*, prevents his psychological growth, and so the will retains its primitive negative form. Any expression of this negative will is condemned by the parents as badness, and this parental attitude gives the individual another reason for denying his will, *i. e.*, for saying in effect: "I am not bad, I have no will at all." Since the will represents the person's individuality, and his happiness depends on his acceptance of his individuality, this denial becomes of great psychological significance. Thus we see that in certain strong-willed persons the will remains predominantly negative and is denied, that is, cannot reach consciousness. But the will continually strives to break down this barrier and appear in consciousness. Here, then, are two opposing forces, consciousness and the negative will, each striving to overcome the other. Of course, the situation is not quite as simple as this; the oversimplification is for the purpose of giving the general idea. I have used the word "predominantly" negative to signify that the will was not completely negative. In many of these strong-willed persons the aberration is too slight to make a major disturbance in their life. But their feeling tone is poor and they do not really enjoy life. Their will tends to oppose their own normal functions (life), as it opposes everything in the outer world, not enough perhaps to make life impossible, but enough to make it unhappy.

1 Rank, Otto: Wahrheit und Wirklichkeit. Leipzig und Wien: Franz Deuticke, 1929.

2 Rank, Otto: Grundzüge einer Genetischen Psychologie. Leipzig und Wien: Franz Deuticke, 1927.

In others the aberration is sufficient to cause a psychoneurosis. Some psychoneurotics, the hysterical type, succeed in keeping all knowledge of the real state of affairs out of consciousness, but transform their suffering into physical symptoms. Others, the compulsion neurotic type, allow the will to reach consciousness as thought.

Let us now return to our discussion of the patient with insomnia. We see that his desire to sleep is an expression of his positive will to live, and his compulsion to thought an expression of his negative will. Since this compulsion to thought preponderates, we must infer that this person's will is predominantly negative and that, whether he admits it or not, he is a borderline psychoneurotic, or actually a psychoneurotic.

This is not the place to discuss the psychological treatment of these individuals. Suffice it to say that proper understanding of the strong-willed person, and of the principles laid down by Rank for therapy of the neuroses, makes it possible to permanently cure the larger part of these patients.

* * *

II. PATHOLOGY

Thomas G. Inman, M. D. (2000 Van Ness Avenue, San Francisco).—Any discussion of the pathology of insomnia must include those conditions responsible for the inability to secure normal sleep, since it is extremely doubtful if insomnia exists as a separate clinical entity. Inactive states are common to all living things, animal or vegetable, simple or complex, and serve to allow, after the expenditure of stored-up energy, a return to a state of stable equilibrium. Sleep, as we know it, in complex organisms, is a provision of nature devised to produce a more or less inactive state of the whole body in order that wasted tissues may repair themselves. The accompanying phenomenon, which we know as unconsciousness exhibited by higher forms, is due to the same inactive state of the upper nerve cell groups, chiefly, in man, the cerebral cortex.

The existence of a sleep center within the brain has been the subject of much discussion, especially since the encephalitis epidemic of 1917-1920. The concentration of the effects of the virus of this disease in the neighborhood of the midbrain and basal ganglia, with the almost constant somnolence, suggested the possibility that there might be located in this region some group of cells which controlled the sleep mechanism. It would seem to be in keeping with nature's efforts in the conservation of energy that some such control should develop in complex organisms in order that all structural units might be brought under control at the same time. However, it cannot be stated positively that such a center actually exists.

Pathological Anatomy.—Disease processes within the cranium may cause insomnia, but usually only in the beginning stages. In tuberculous meningitis, sleeplessness or restless and troubled sleep may be the first noticable symptom. On such a basis sometimes rest the "night terrors" of children. Septic meningitis and lethargic encephalitis frequently cause a few sleepless nights at the beginning of the illness. Cortical parenchymatous syphilis, cortical atrophy due to arteriosclerosis and decortication from any cause notoriously disturb the sleep cycle.

Tumors developing within the cortical sensory projection centers may, by stimulation, arouse the respective images common to that region and make sleep impossible. With the increase in intracranial pressure, however, or when tumors or inflammatory disease invades the region of the third ventricle, somnolence is the rule.

Pathological Physiology.—Increase in the rate of blood flow through the brain, brought about by various causes such as hyperthyroidism or an increase in the activity of other glands of internal secretion, may be the cause of obstinate sleeplessness. Some of these hormones act upon the cortical cells directly lowering the threshold of irritability.

There is a class of individuals who, in the absence of any special disease, are poor sleepers. They usually possess a more or less unstable vasomotor system to which may be added a volatile emotional nature. With them may be grouped the so-called visceroptotic type. The long body, small, central heart, low-lying abdominal viscera and poorly developed musculature lend themselves to a poorly sustained systolic pressure when standing. On assuming the horizontal position the blood is more evenly distributed, and the cerebral circulation takes on the character belonging to the waking period. Thus, tired and sleepy before retiring, once they are in bed they become wide awake and, like Achilles, bemoaning the death of Patroclus, lie first on one side, then on the other, now on the back, now on the face. Only when circulatory readjustment takes place do they fall asleep.

Pathological Psychology.—Under this heading most of our patients whose chief complaint is the inability to secure sufficient sleep may be placed. There are two main groups, the neuropathic and the psychopathic. In the former, mental conflicts cause psychovisceral reactions which, activating circulatory and glandular modalities, stimulate cortical cellular interplay within the sensory centers. Thus, phantasy formation, anxiety, real and imaginary fears and feelings of resentment prevent that relaxation without which sleep is impossible.

The various psychoses are frequently marked by obstinate sleeplessness, but the associated mental state soon makes itself known. There is one group, however, in which the underlying cause is not so readily apparent. It comprises those mild, sometimes recurrent, depressive states in which insomnia is frequently the only complaint. Observation will detect the gloomy aspect, and questioning elicit the fact that the mood is sad and pessimistic; that they are emotionally depressed, have no appetite and are unable to obtain any pleasurable feeling from the pursuit of those occupations and hobbies which they formerly enjoyed. These symptoms, which mark the underlying psychosis, are often overlooked because of the reiterated statements of the patient that he would be all

right if he could only sleep. Aside from pointing the way to suitable treatment, early recognition of the true state of affairs is necessary, for any sudden deepening of the psychosis may usher in that most important symptom—the impulse to suicide.

It cannot be stated positively that loss of sleep *per se* leads to any pathological alteration in the tissues of the human body. Chromotolysis has been observed within important cellular groups in the central nervous system in animal experiments. The findings, however, may not depend wholly upon a disturbance of the sleep mechanism, but upon associated phenomena.

* * *

III. TREATMENT

H. Douglas Eaton, M.D. (1136 West Sixth Street, Los Angeles).—Sleep, nature's preventive for excessive fatigue, is an involuntary habit. Insomnia is a disturbance of the sleep habit, and may occur in varying degrees in a multitude of diseases or simply as a result of bad sleep habits. Insomnia is a symptom, not a disease; and its adequate treatment is dependent on ascertaining the cause for its existence with elimination of this underlying condition. When the fundamental cause cannot be removed, or while it is being corrected, symptomatic treatment of the insomnia is often of great benefit to the patient. In a certain percentage of cases, relief of insomnia may be the determining factor in the patient's recovery.

In organic disorders, when the lack of sleep is directly due to severe and continuous pain, analgesics may be combined with hypnotics to give the patients the periods of relief from pain and the mental oblivion so essential to their recovery. The milder, less depressing, drugs should be tried at first. The combination of salicylic acid with moderate doses of some of the barbiturates is often sufficient. In more severe cases the opium derivatives, alone or combined with hypnotics, are justifiable. Codein or morphin combined with a barbiturate suffices in a large percentage of cases. Hyocin and morphin, in the familiar HMC combination, is a still more potent preparation. The intramuscular route of administration is most efficient when quick results are desired. Intravenous medication is, in the writer's experience, neither desirable nor necessary. Physiotherapy, especially hydrotherapy, may be considered, but is usually impractical in this group of cases. Its detailed discussion will be reserved until later.

Toxic causes are prime offenders in the production of insomnia. Coffee in excess, or even very moderate amounts of coffee in susceptible individuals, is a well-recognized sleep disturber. Alcohol or the excessive use of tobacco; tea, dietary indiscretions, the lack or overabundance of physical exercise, may cause insomnia. Some drugs, of which a notable example is benzedrin sulphate, easily upset the sleep habit. Insomnia is a frequent symptom in infectious diseases, acute or chronic. Obviously, the successful treatment of insomnia so produced depends on elimination of its toxic cause. While this is being accomplished, symptomatic treatment of the insomnia is often indicated. In this group of cases hydrotherapy holds a definite therapeutic place. The warm bath, starting the first night at 98 degrees and reducing a degree nightly to 90 degrees, is often very satisfactory. As the bath exerts its sedative and hypnotic effect through redistribution of the blood supply, it is essential that the patient be transferred from the bath to a warmed bed, and not allowed to become chilled in transit if good results are to be obtained. If a tub bath is not practicable, the bed pack may be given. Here, when the mattress is protected by rubber sheeting, the patient is wrapped in a sheet, wrung out in tap water, then in two layers of blankets. With the use of the tub or pack, cold compresses or an ice-bag to the head, may be used. Either tub or pack may be continued under supervision from thirty minutes to an hour or longer, depending on the patient's reaction.

Aside from hydrotherapy, the use of the milder hypnotics may be necessary. Many patients will sleep with the aid of bromid alone. The accumulative effect of this drug, as well as the marked individual variations in susceptibility to it, must always be borne in mind. Of the older drugs, chloral hydrate is of value. Paraldehyd is a relatively safe hypnotic and of special value in insomnia due to alcoholism. Its use is limited by its disagreeable taste and odor. There are at the present time a large number of barbiturate preparations on the market which, when used in moderation and under medical supervision, are satisfactory hypnotics for short periods. The possibility of a barbiturate habit must be guarded against. The scope of this discussion does not permit a detailed résumé of these preparations.

In the psychoses, insomnia is often an intractable and serious symptom. In this group, hydrotherapy is an extremely valuable therapeutic procedure. As most of these cases are under treatment, where the continuous bath is available, this should be first choice. The continuous bath is best given at body temperature, and it should never be given at more than one or two degrees above this. It should always be given under constant expert supervision, and any form of mechanical heat control of the water should be checked frequently by other means. The bed pack, given as previously described, is also of great value. Either continuous bath or pack may be continued for hours in suitable cases under strict observation. In severe excitements, hydrotherapy must often be combined with the use of sedatives and hypnotics. Here the barbiturate group alone, or combined with regular daily bromid administration, is of great value. Chloral alone, or combined with a barbiturate, is often satisfactory. Paraldehyd is especially valuable in the alcoholic psychoses. Finally, recourse may be had to hyoscin alone or combined with morphin in HMC's. The mode of administration depends on the patient's accessibility. Mouth and rectal administration may be tried. Recourse to the nasal tube or intramuscular injection is frequently necessary. Intravenous introduction need not be considered.

Insomnia is such a common symptom in functional nervous disorders that one rarely sees a

psychoneurotic who has not suffered from some degree of sleep disturbance at some time during illness. Here psychic causes are in the ascendancy, and successful therapy is dependent upon their elimination. Nervous insomnia is not simply a disturbance in sleeping, but a mental state colored colored by fear and anxiety in regard to not sleeping. Therapy should be primarily reëducational in type. Rationalization of the situation, combined with the correction of faulty habits of living, and especially of rest and relaxation, often suffices without medicinal aid. Hydrotherapy, especially the moderately warm bath previously described, is of definite value. Massage, preferably given shortly before bedtime, is helpful in a definite percentage of cases. The milder hypnotics are permissible only as an aid to psychotherapy and must be rigidly supervised and controlled. The habit of dependence on drugs is exceedingly easy for the psychoneurotic to acquire and frequently results in more harm than the sleep disturbance.

Principles in Procedures in Treating Syphilis:

1. Treatment of early syphilis should be continuous.

2. Spinal fluid examinations should be made routinely at the end of the first year of treatment and as indicated at any time.

3. Complete physical examinations with special attention to the cardiovascular and nervous systems, and including suitable laboratory tests, should be routinely made at least at the beginning of treatment.

4. Patients having suspicious lesions which are found to be darkfield negative, should be followed up by a series of serological tests at suitable intervals, and no local or constitutional treatment should be administered until the diagnosis has been established.

5. Minimum treatment required:

(*a*) To render patient noninfectious, twenty standard doses of an arsphenamin and twenty doses of bismuth administered by the continuous method of treatment.

(*b*) To "cure" the patient: One year of treatment after the patient has become and remained clinically and serologically negative (including spinal fluid).

6. All patients having syphilis should be examined for gonorrhea. All patients having gonorrhea should be examined for syphilis.

7. Epidemiological service by trained personnel should be adequately provided to supplement the efforts of the doctors in:

(*a*) Seeking to trace the sources of infection.

(*b*) Bringing in the contracts of patients for examination.

(*c*) Holding patients long enough under continuous and adequate treatment.

(*d*) Thorough personal instruction of patients to assure coöperation.

Management of Syphilis in Pregnancy and Congenital Syphilis

1. Every pregnant woman should have a medical examination as early as possible in pregnancy, this examination to include adequate history, clinical and serological examinations fo rsyphilis.

2. Every pregnant woman should have at least one complement-fixation test and one precipitation test for syphilis, and these tests should be reported when negative or doubtful, if there is any reason in the history or clinical findings to suspect syphilis.

3. Treatment of syphilis as a complication of pregnancy should start as soon as a diagnosis is made, should continue through pregnancy to delivery. Treatment should begin and end with the arsenical; if pushed for time, use combined treatment—bismuth with the arsenical.

4. A syphilitic woman should be treated in every pregnancy regardless of previous treatment, and regardless of negative serological findings. Even a few doses of arsphenamin late in pregnancy are better than no treatment at all.

5. Treatment should be continued after delivery for the benefit of the mother.

6. Every child of a syphilitic woman, and the woman's husband, should be examined for syphilis and treated, if indicated.

7. The child born of a syphilitic woman should not be treated "on suspicion," but only after a definite diagnosis has been made, and treatment should be started as soon as a diagnosis is made. The earlier a congenital syphilitic child is treated for syphilis the better, and the treatment must be prolonged.

8. The new-born child of a syphilitic woman, even though the mother has been treated, should be followed with frequent serological, clinical and x-ray examinations. This periodical supervision should extend, if possible, until the seventh year.

9. The stigmata of congenital syphilis should be kept in mind by all who examine children. When a suspicious defect is seen, a careful study, including blood, x-ray examination, and spinal fluid serology, should be made.

10. Even late congenital syphilis benefits by treatment in the vast majority of cases.

"The conception is sometimes held that when the signs of meningeal irritation are demonstrable, one can conclude that the patient is suffering from a meningococcus infection. Such deductions are often incorrectly drawn. Merely on the basis of probabilities, one would be more apt to be correct in diagnosing tuberculous meningitis than any other type of meningitis in a given case, since this is the most common cause of meningeal irritation, except in epidemics of meningococcus infections.

"Meningeal irritations may be caused by (*a*) bacteria of any kind, no matter how rare, but most often by staphylococci, streptococci, meningococci, tuberculosis or influenza bacilli, and mixed organisms, including the colon bacilli; (*b*) toxins produced by such organisms as B. tetanus, influenza, probably pneumococcus and B. tuberculosis; (*c*) viruses causing encephalitis, poliomyelitis, aseptic meningitis, idiopathic encephalitis, postvaccinal encephalitis, encephalitis associated with measles, chickenpox encephalitis and others of similar type; (*d*) occasionally, as the result of mechanical condition such as blocks and vessel thromboses, inflammation of adjacent cranial bones, subdural and spontaneous subarachnoid hemorrhages, more rarely as the result of edema, tumor, etc.; (*e*) occasionally, as a result of changes in the brain associated with lead poisoning, etc."—*Ohio Health News.*

Mechanism of Emotion.—Papez attempts to point out various anatomic structures and correlated physiologic symptoms which, taken as a whole, deal with the various phases of emotional dynamics, consciousness and related functions. It is proposed that the hypothalamus, the anterior thalamic nuclei, the gyrus cinguli, the hippocampus and their interconnections constitute a harmonious mechanism which may elaborate the functions of central emotion as well as participate in emotional expression. It is an attempt to allocate specific organic units to a larger organization dealing with a complex regulatory process. The evidence presented is mostly concordant and suggestive of such a mechanism as a unit within the larger architectural mosaic of the brain. The structures described here are usually represented as dealing with some phase of the olfactory function. There is no clinical or other evidence to support this view. Emotion is such an important function that its mechanism, whatever it is, should be placed on a structural basis. The organization presented here meets adequately the physiologic requirements proposed by Cannon and Bard with respect to the theory of emotion based on diencephalic-cortical processes. It is also in agreement with the observations of Dandy that the seat of consciousness is located somewhere near the midline, between the limits set by the corpus callosum and the basal structures of the brain.—*Archives of Neurology and Psychiatry.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

HOWARD MORROW.....President
WILLIAM W. ROBLEE.....President-Elect
LOWELL S. GOIN.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

OFFICIAL BUSINESS

1. *Council Minutes, Two Hundred Fifty-ninth Meeting, January 15, 1938.*

COUNCIL MINUTES

Minutes of the Two Hundred and Fifty-Ninth Meeting of the Council of the California Medical Association*

Held in the auditorium of the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles, Saturday, January 15, 1938, at 9 a. m.

1. **Call to Order.**—The meeting was called to order by the chairman, Morton R. Gibbons, with the following members present: President Howard Morrow, President-Elect William W. Roblee, Past President Edward M. Pallette, Speaker Lowell S. Goin, Chairman of the Council Morton R. Gibbons, Chairman of the Auditing Committee Karl L. Schaupp; Councilors Calvert L. Emmons, Carl R. Howson, Louis A. Packard, Axcel E. Anderson, Alfred L. Phillips, O. D. Hamlin, F. N. Scatena, Henry S. Rogers, Harry H. Wilson, C. O. Tanner, W. H. Kiger, J. B. Harris; Chairman of Public Relations Committee Charles A. Dukes, Secretary F. C. Warnshuis, Editor George H. Kress, General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard. Present by invitation at the afternoon session: George G. Reinle, William Molony, Dewey Barnard, A. A. Morrison, and C. A. Smolt.

2. **Charters.**—It was moved by Henry Rogers, seconded by Alfred Phillips, that the Secretary be authorized to issue duplicate charters to those county societies who do not hold original charters in their possession; such charters to be labeled "duplicate" and to be dated as of the date of the organization of the county society if available, or as of the date of reorganization of the California Medical Association, 1902. Carried.

3. **Membership.**—The relation of members who have been granted special types of membership in county societies, *i. e.*, associate, retired, honorary, to the California Medical Association and the American Medical Association and the advisability of providing for a type of membership which would permit these members to retain their state and national affiliation was discussed.

It was moved by Alfred Phillips, seconded by William Kiger, that a committee of three be appointed by the Chairman to investigate the matter of membership and report with recommendations to the Executive Committee. Carried.

The Chairman appointed Doctors Goin, Howson, and Scatena as members of the committee.

4. **Delegates.**—The Secretary submitted a report on the delegates and alternates regularly elected to represent the California Medical Association at the American Medical Association meeting in San Francisco.

5. **Postgraduate Conferences.**—It was moved by Howard Morrow, seconded by Edward Pallette, that the chairman of the Committee on Postgraduate Instruction be allowed the necessary expense entailed by attendance at the Chicago Conference on Postgraduate Instruction, in the event of his attendance. Carried.

6. **Advertising.**—In accordance with action of the Executive Committee, the Secretary reported that he had conferred with the Los Angeles County Medical Association's executive secretary and it was agreed that he should ask the authority of the Council to make a combination rate for advertising in the JOURNAL and the Los Angeles County Medical Association Bulletin.

It was moved by Howard Morrow, seconded by Karl Schaupp, that a plan of a combination rate for advertising in the JOURNAL and the Los Angeles Bulletin under the conditions outlined by the Secretary be approved. Carried.

7. **Medical Licensure.**—In view of the pending meeting of the Council on Medical Education and Hospitals of the American Medical Association, the discussion of medical licensure was referred to the next meeting of the Council, when more information would be available.

8. **Reporting Service.**—It was moved by Charles Dukes, seconded by Junius Harris, that the services of Yates Reporting Service be secured for reporting the five meetings of the Pasadena session, in accordance with their proposal of December 30, 1937. Carried.

9. **Minutes.**—On motion of Alfred Phillips, seconded by Edward Pallette, the minutes of the two hundred and fifty-third meeting of the Executive Committee were approved.

On motion of Alfred Phillips, seconded by Edward Pallette, the minutes of the two hundred and fifty-seventh and two hundred and fifty-eighth meetings of the Council were approved.

10. **Insurance.**—It was moved by George Kress, seconded by Charles Dukes, that a committee, consisting of the Chairman of the Council, the Secretary, and the General Counsel, be instructed to investigate the status of a certain insurance company operating in California and report to the Executive Committee, which shall have the power to act. Carried.

11. **Financial Report.**—The Secretary presented, for the information of the Council, the annual report of the finances of the Association as compiled by Ernst & Ernst, certified public accountants. This will be published in the Pre-Convention Bulletin.

12. **Legal Counsel.**—It was moved by Edward Pallette, seconded by Karl L. Schaupp, that the Legal Counsel be authorized to render an opinion upon certain matters pertaining to medical education. Carried.

13. **Councilor Expense.**—It was moved by Charles Dukes, seconded by Howard Morrow, that the expense incurred by Lowell Goin, referee at the hearing of the San Diego County Society, be approved for payment by the California Medical Association. Carried.

14. **Cancer Studies.**—In accordance with the suggestion of the Cancer Commission, on motion of Charles Dukes, seconded by George Kress, the Council approved the donation of one copy of the Cancer Studies to all members of the graduating classes of the four medical schools in California and to the house staff members in the San Francisco, Alameda, and Los Angeles County Hospitals. Carried.

15. **Lay Speakers.**—It was moved by Charles Dukes, seconded by Axcel Anderson, that in lay talks on cancer by speakers of the Association, the educational campaign as carried on by the Women's Field Army in coöperation with the American Society for the Control of Cancer, be called to the attention of audiences. Carried.

* The minutes of the two hundred and fifty-eighth meeting of the Council of the California Medical Association were printed in the November, 1937, issue of CALIFORNIA AND WESTERN MEDICINE, page 336. Minutes in this series now printed are for the two hundred and fifty-ninth meeting.

16. **Department of Public Health.**—The attention of the Council was called to the work of the Department of Public Health as outlined in a report by Director of Public Health Walter M. Dickie, and on motion of George Kress, seconded by Howard Morrow, the report was ordered published. Carried.

17. **Legal Department.** — The General Counsel submitted progress reports on the case of the *People* vs. *Pacific Health Association,* stating that further arguments would be heard in June, and a case in Santa Clara County.

18. **Loans to County Societies.**—The Secretary read the following report of the Special Committee on Loans to County Societies:

Your Committee recommends that the loan be not granted for the following reasons:

1. It would be setting a precedent that might lead the Association into future difficulties. Our monetary assets are only sufficient for a reserve to be used as needed for special purposes. Examples are the recent medical-economic survey, the Basic Science Initiative, and the possibility that the malpractice insurance situation may become so unsatisfactory that the Association may find it necessary to organize a mutual company for the protection of its members. The reserve funds of the Association are now invested in securities bearing a moderate rate of interest that can be readily turned into cash if it is needed.

2. If a loan is granted to one county unit, similar requests from other county units would probably be received. Adequate security, ease of conversion, and other factors essential in a loan placed on a business basis would be difficult to obtain.

Respectfully submitted,

LOWELL S. GOIN, M.D. (Signed)
CHARLES A. DUKES, M.D. (Signed)
W. W. ROBLEE, M.D. (Signed)

On motion of William Roblee, seconded by Howard Morrow, the report was approved and the recommendations contained therein were declared to be the policy of the Association in regard to loans to county societies. Carried.

19. **Medical Licensure.**—Full discussion was had of the practice of certain county hospitals in allowing unlicensed individuals to serve as residents and in some cases accept patients outside of the hospitals.

It was moved by Harry Wilson, seconded by Charles Dukes, that the Secretary be instructed to write to Charles B. Pinkham, Secretary of the Board of Medical Examiners, and William R. Molony, President of the Board, and call their attention to the facts that have been presented to the Council wherein practitioners that are unlicensed are practicing in county hospitals.

A vote was taken on the motion. Ayes, 11; Noes, 4. Motion carried.

20. **County Hospitals.**—Henry Rogers presented the resolution of the Board of Supervisors for the government of the Sonoma County Hospital. Full discussion was had of the general question of county hospital government and the desirability of a nonpolitical institutions commission.

It was moved by Louis Packard, seconded by Axcel Anderson, that the Chairman appoint a committee to assemble facts concerning this county hospital situation, especially in regard to an Initiative regulating government of county hospitals, said committee to report to the Executive Committee at its meeting in February. Carried. (Committee—Doctors Packard, Anderson, and Emmons.)

21. **Orange County Hospital.**—It was moved by Junius B. Harris, seconded by Chester Tanner, that the resolution of the Orange County Society relating to sex crimes be referred to the California Crime Commission. Carried.

22. **Recess.**—At this point a recess of the Council was called for luncheon, to reconvene at 2 p. m.

23. **Call to Order.**—The meeting was called to order after the recess by Chairman Gibbons.

24. **Basic Science Act.**—George H. Kress, General Chairman of the Committee on the Basic Science Act, submitted a report for his committee together with tentative drafts of several basic science acts and legal points involved as set forth by the General Counsel.

It was moved by Charles Dukes, seconded by William Roblee, that the report be received and that the Association postpone the sponsoring of the Basic Science Initiative until the 1940 General Election, and that the committee be instructed to continue its studies.

A vote was taken on the motion. Ayes, 14; Noes, 4. Doctors Pallette, Kiger, Goin, and Wilson voted in the negative. Motion carried.

25. **Birth of a Baby.**—After viewing a portion of the picture "Birth of a Baby," and taking cognizance of the present sponsors of the film, on motion of Karl Schaupp, seconded by O. D. Hamlin, it was moved that the film be approved for presentation to lay audiences.

A vote was taken on the motion. Ayes, 11; Noes, 5. Motion carried.

26. **Medical Service.**—Doctor Smolt of Ventura presented plans being offered for medical service in Ventura County and stated that the county society also wished to offer a plan.

It was moved by Harry Wilson, seconded by Charles Dukes, that the Ventura County Medical Society plan for medical service be submitted to the Committee on Public Relations, which will hear representatives of the Ventura Society and report to the Executive Committee. Carried.

27. **Budget.**—The budget for Association income and expense for the year 1938-1939 was submitted by the Chairman of the Auditing Committee and on motion of Karl L. Schaupp, seconded by Lowell Goin, was approved for submission to the House of Delegates. Carried.

28. **Committee on Arrangements.**—It was moved by O. D. Hamlin, seconded by Karl Schaupp, that the nominees for the local Committee on Arrangements as submitted by the Los Angeles County Medical Association, be approved. Carried.

29. **Annual Session.**—The Secretary reported that the Committee on Scientific Work recommended that a general public meeting be held on Tuesday evening during the annual session at Pasadena and that the coöperation of the Los Angeles County Medical Association was being secured.

It was moved by Lowell Goin, seconded by Henry Rogers, that the following nonmembers of the Association be invited to participate in the annual session program in accordance with the request of section officers: Nina Simmonds, Ph.D., Mr. Cheney, chemist; Mr. Leonard, and Mr. Warner, radiological technician.

It was moved by Edward Pallette, seconded by O. D. Hamlin, that the Secretary be instructed to investigate the matter of purchase of new stereopticon lanterns and screens for use by scientific sections and report to the Executive Committee. Carried.

On motion of William Roblee, seconded by Howard Morrow, the invitation to Frank Hartman, M. D., of St. Louis, to be one of the guest speakers of the Association at Pasadena, was approved.

30. **Memberships.**—After presentation of requests from county societies and submission of full membership data, on motion of Edward Pallette, seconded by O. D. Hamlin, and carried, the following members were granted retired membership in the California Medical Association: Thomas Orbison, Los Angeles; Ernest W. Fleming, Los Angeles; Frank S. Dillingham, Los Angeles; E. L. Bennett, Fresno; Francis P. Elliott, San Diego; Ernest B. Porter, San Diego; Alfred Baker Spalding, San Francisco; and Caroline B. Palmer, San Francisco.

31. **Associated Hospital Service of Southern California.** — The Secretary reported that the plan of the Associated Hospital Service of Southern California had received the approval of the Los Angeles County Society and the Committee on Public Relations.

After discussion, it was moved by Edward Pallette, seconded by William Kiger, that the plan of organization of the Associated Hospital Service of Southern California be approved. Carried.

32. **Vote of Appreciation.**—A standing vote of thanks was tendered Dr. George H. Kress for the work he had done in connection with the publication of the "Report on Factual Data" of the California Medical-Economic Survey.

33. **Trustees Of The California Medical Association.** It was moved by Karl Schaupp, seconded by Edward Pallette, that the California Medical Association repay the $31,000 loan to the Trustees Of The California Medical Association. Carried.

34. **Malpractice Insurance.**—George G. Reinle, Chairman of the Committee on Medical Defense, outlined the changed status of medical defense which has developed during the past few years and through the decision of the

American Bar Association on corporate practice of law. The amendments to the by-laws and defense rules of the Medical Society of the State of California were brought to the attention of the Council. After briefly referring to the various types of liability insurance, Doctor Reinle requested Mr. Peart to present the question to the Council. Mr. Peart then read an extended report on malpractice insurance and made certain recommendations as to policy.

It was moved by George Kress, seconded by William Roblee, that the Committee on Medical Defense, in cooperation with the General Counsel, prepare basic policies for medical defense with such other recommendations as in their judgment are deemed advisable and present the report to the Executive Committee for transmission to the Council. Carried.

35. **Death of Emmet Rixford.** — It was moved by Charles Dukes, seconded by William Roblee, that a committee be appointed by the Chairman to draw up suitable resolutions on the death of Emmet Rixford and that the resolutions be spread on the minutes of this Association. Carried. (Committee—Doctors Hamlin, Toland, Dukes.)

36. **Woman's Auxiliary.**—It was moved by George Kress, seconded by Chester Tanner, that the Editor be authorized, when suitable material is presented, to publish a supplement to the JOURNAL for the Woman's Auxiliary of the California Medical Association. Carried.

37. **Disciplinary Procedure.**—After discussion, Lowell S. Goin was appointed to bring in amendments to the present by-laws covering disciplinary procedure.

38. **Intercoast Hospitalization Insurance Association.** On motion duly made, seconded and carried, the minutes of the two hundred and fifty-third meeting of the Executive Committee were reconsidered.

On motion duly made, seconded and carried, the action of the Executive Committee in regard to the Intercoast Hospitalization Insurance Association was ordered deleted from the minutes of the committee.

It was moved by Fred Scatena, seconded by Lowell Goin, that the present form of policy of the Intercoast Hospitalization Insurance Association be approved by the California Medical Association. Carried.

39. **Executive Minutes.**—On motion duly made, seconded and carried, the minutes of the two hundred and fifty-third meeting of the Executive Committee were approved as amended.

40. **Adjournment.**—There being no further business, the meeting adjourned at 4:45 p. m.

MORTON R. GIBBONS, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *American Medical Association Local Committee on Arrangements for San Francisco Session, June 13–17, 1938.*
2. *Association Nights.*
3. *The Medical Society of the State of California.*
4. *Passing Comments.*

DEPARTMENT OF PUBLIC RELATIONS

1. *The Social Aspects of Heart Disease.*
2. *San Mateo County Medical Society.*
3. *Important.*
4. *Porter versus King County Medical Society.*

ASSOCIATION ACTIVITIES

AMERICAN MEDICAL ASSOCIATION LOCAL COMMITTEE ON ARRANGEMENTS FOR SAN FRANCISCO SESSION JUNE 13–17, 1938

The Board of Trustees of the American Medical Association has appointed Dr. Howard Morrow of San Francisco as General Chairman of the Local Committee on Arrangements for the annual American Medical Association session that is to convene in San Francisco the week of June 13, 1938.

Doctor Morrow, under authority conferred, was empowered to appoint the necessary local committees. Attached is a list of Doctor Morrow's appointments.

Executive Board—Howard Morrow, chairman; Alanson Weeks, treasurer; Junius B. Harris, Sacramento; George A. Reinle, Oakland; J. C. Geiger; L. R. Chandler; F. C. Warnshuis, secretary.

Finance—Alanson Weeks (chairman), Langley Porter, W. P. Shepard, Charles A. Dukes, Chauncey D. Leake.

Hotel and Housing—F. C. Warnshuis.

Publicity—J. C. Geiger (chairman), E. M. Pallette, Karl S. Schaupp.

Entertainment—W. D. Horner (chairman), W. W. Washburn, Garnett Cheney, Everett Carlson, Stacy Mettier, Edwin Bruck, Philip Arnot.

Alumni and Fraternity Banquets—Rea Ashley (chairman), John Cline, William Donald of Berkeley, Joseph Crawford.

Women's Entertainment Committee—Mesdames George Becker, Chauncey Leake, Edward Morrissey, Lewis Morrison, Jesse Carr, Howard Fleming.

Opening General Session—William J. Kerr (chairman), LeRoy Briggs, Arthur H. Bloomfield, Morton Gibbons, H. C. Moffitt.

President's Reception and Ball—H. C. Shepardson (chairman), Hans Barkan, D. K. Pischel, Fred Reichert, Edmund Butler, George Rhodes, Philip Arnot, Robertson Ward, W. D. Horner, Howard Fleming, Wilbur F. Swett, Francis Smyth, Stacy Mettier, Edwin Bruck.

Printing and Badges—F. C. Warnshuis.

Women Physicians—Alice Maxwell (chairman), Dorothy W. Atkinson, Mary Mathes, Lois Broek Watson, Huldah Thelander, Alice Bepler.

Golf Committee—James Morgan (chairman), George McClure, Ernest Chipman, George Gray, W. G. Moore, Joseph McCool.

Hospitals and Clinics—W. E. Carter (chairman), C. A. Walker, Howard Johnson.

Transportation, Taxis, and Tours—Laurence R. Taussig (chairman), Carl Hoag, Harold Fletcher, George Becker.

Opening General Meeting Clergyman—Reverend Dutton, Unitarian.

Registrations and Information—S. P. Lucia (chairman), Richard Friedlander, Edgar Munter, L. H. Garland, N. N. Epstein, G. Dan Delprat.

Woman's Auxiliary.—Mrs. J. C. Geiger (chairman), Mrs. John Humber, Mrs. Hobart Rogers of Oakland.

Invited Guests Entertainment—Clarence Toland (chairman), George H. Kress, E. M. Pallette, Junius B. Harris, W. W. Roblee, John H. Graves.

Sections and Section Work—

(a) *Medicine*—Thomas Lennon (chairman), H. G. MacLean of Oakland, De Witt K. Burnham, Kenneth D. Gardner, Clayton Mote.

(b) *Surgery—General and Abdominal* — A. R. Kilgore (chairman), Edmund Butler, Robertson Ward, G. D. Delprat, H. Brody Stephens, Henry H. Searles, W. W. Washburn.

(c) *Obstetrics*—P. H. Arnot (chairman), A. M. Vollmer, C. A. De Puy, Karl Schaupp, T. Henshaw Kelly.

(d) *Ophthalmology* — Otto Barkan (chairman), F. C. Cordes, A. E. Edgerton, Wilbur Swett.

(e) *Laryngology, Otology, Rhinology* — R. C. Martin (chairman), Rea Ashley, Lewis Morrison, George McClure.

(f) *Pediatrics*—E. B. Shaw (chairman), George D. Lyman, Francis Scott Smyth.

(g) *Pharmacology and Therapeutics* — Chauncey D. Leake (chairman), P. J. Hanzlik, Maurice Tainter.

(h) *Pathology and Physiology*—A. M. Moody (chairman), J. L. Carr, J. F. Rinehart, William Doek, P. Michael of Oakland.

(i) *Nervous and Mental Diseases*—Edward W. Twitchell (chairman), George Johnson, P. A. Gliebe.

(j) *Dermatology and Syphilology* — John M. Graves (chairman), C. J. Lunsford, F. G. Novy.

(k) *Preventive and Industrial Medicine and Public Health*—J. C. Geiger, Walter Dickie, Robert Legge.

(l) *Urology* — Clark M. Johnson (chairman), Sidney Olsen, Lloyd R. Reynolds.

(m) *Orthopedic Surgery*—H. H. Hitchcock (chairman), F. C. Bost, W. J. Cox, John Loutzenheiser.

(n) *Gastro-Enterology and Proctology* — Fred Kruse (chairman), Dudley Smith, Montague Woolf, Walter Boardman, M. F. Cunha, Edward Hanlon, J. W. Morgan.

(o) *Radiology*—H. E. Ruggles (chairman), R. R. Newell, I. S. Ingber, Carl Benson Bowen, Lloyd Bryan.

(p) *Technical Exhibits*—T. L. Althausen (chairman).

(q) *Scientific Exhibits* — Stanley Mentzer (chairman), Howard B. Dixon, C. Latimer Callander, Willard Kay, Ernest Gehrels.

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

ASSOCIATION NIGHTS

On January 4 President-Elect Roblee, Councilor Emmons, and the State Secretary attended a joint dinner meeting of the members of the San Bernardino-Riverside County Societies in San Bernardino. A splendid large and representative attendance of the members of these two fine, active societies was recorded. Commendable unity exists and wholesome influence is exerted in these two counties.

On the 5th, Speaker Goin joined these officers for a meeting of the members of Orange County in Santa Ana. Here, too, a fine turnout of members participated in the program. Orange County also reflects an alert, achieving membership.

On the 6th the party journeyed to El Centro, where that evening the members of the Imperial County Society turned out in goodly numbers for a dinner meeting. This is a 100 per cent county society and, while distant from larger metropolitan centers, these members are keenly alert and reflect commendable activity.

On the 7th the circuit ride was extended to San Diego, where at a dinner meeting that evening a large, gratifying number of the members in San Diego County were present.

At all of these "Association nights" the visiting officers present and discuss problems and questions that concern our Association, its members, and the public. Policies are outlined and relations are clarified. Each session is terminated by conducting a round-table of questions and answers.

These Association nights afford an opportunity for members to gain a clearer insight of our Association affairs and functionings, thereby making for better understanding. A better grasp is obtained upon questions that are vital to individual and organizational welfare. They are conducive to greater unity of purpose and support. The visiting officers also become informed upon local conditions and needs, which information is made available to our administrative bodies and committees.

The first councilor district is well organized, active, and composed of a splendid group of medical men.

MEDICAL SOCIETY OF THE STATE OF CALIFORNIA*

The Medical Society of the State of California is an *independent* organization composed of *members* of the California Medical Association.

Purpose

The purpose of the Society is to indemnify or reimburse its members for expenses incurred for the legal services of a *personal* or *private* attorney whenever a member is threatened or sued for alleged malpractice.

Membership Qualifications

A member in good standing in his county medical society may become a member of this *Society* by complying with the following conditions:

(*a*) Filing membership application with the Society's secretary.

(*b*) Holding a policy with an insurer authorized by law to issue physician's defense and indemnity policies and with coverage of at least $5,000.

(*c*) Payment of annual dues of $10.

Why You Should Be a Member

1. Membership means that you have the privilege of indemnification for the cost of your *personal* attorney in any claim or suit for malpractice brought against you.

2. In the event of a dispute with your insurance company (which in the past has not been an uncommon experience) your *personal* attorney will protect your interests and cause your insurance company to fulfill the terms of your policy.

3. Although your liability insurance policy provides you with the services of an attorney, that attorney, under the ethics and principles of his profession, *must represent your insurance carrier first* and hence his defense of you is directed to the fulfillment of his client's conception of its contract with you, and it is the company's interests which he must at all times protect.

4. A *personal* attorney provides for you a personalized supervision of and participation in, all legal problems and trial conduct, thus assuring full protection of your *personal* and professional interests.

5. This Society reimburses you or indemnifies you for expenses for the services of an attorney who will coöperate with your insurance company's attorney, thereby providing you with competent *personal* legal counsel.

6. Insurance companies operating in this field welcome the assistance your personal attorney can give them.

How to Join

1. Write to the Secretary, Medical Society of the State of California, Room 2004, 450 Sutter Street, San Francisco, California, for membership application blank.

2. Complete the application blank and send it to the Secretary with your check for $10 for your annual dues.

3. If your application is approved, a membership card will be sent to you.

You will then have adequate and necessary legal protection.

JOIN NOW

* * *

Board of Trustees

Morton R. Gibbons, San Francisco; George G. Reinle, Oakland; O. D. Hamlin, Oakland, Chairman; J. B. Harris, Sacramento, Vice-Chairman; Edward M. Pallette, Los Angeles; George H. Kress, Los Angeles; T. Henshaw Kelly, San Francisco.

Executive Committee

O. D. Hamlin, Chairman; F. C. Warnshuis, Secretary; J. B. Harris, Vice-Chairman; M. R. Gibbons.

PASSING COMMENTS

"The Editor's Easy Chair." Such is the heading of a section of some journals wherein editorial comment is recorded. Such a chair should be placed in the Smithsonian Institute for its rarity value. Many years of travel and inquiry have failed to produce such a piece of furniture for inspection, let alone use. The "Editor's Chair" is never an easy one, for if that officer is alert to his responsibilities and duties, it well-nigh becomes a seat of torture.

* * *

Are you joining with your fellow members in obtaining the personal benefits from the postgraduate conferences in your district? This opportunity should not be neglected.

* * *

Four months and then our annual session will convene in Pasadena. Decide to attend and write today for your hotel reservation to the manager of the Hotel Huntington.

* * *

The Society for the Protection of Medical Research is approved by our Association. Its purpose is to direct scientific research and to defeat the quests of those who seek to prevent animal experimentation by legislation.

* * *

The scientific program for our annual session in Pasadena May 9–12, has been completed and was approved at a meeting of all section officers in Santa Barbara on January 9. This program should prove to be of interest and value, and cause the Pasadena meeting to be most profitable to all who attend. The program will be announced in all details in the April issue.

* * *

Be sure to read the item on the Medical Society of the State of California published in this department. You do well to become affiliated.

* * *

The headquarters office of the Association belongs to all the members to which they can apply for information and assistance. It has no magic forces that can immediately solve all the problems of a member. However, material assistance is at your disposal whenever you feel the need of assistance. Be free to command it. Your inquiries are welcomed and will be accorded prompt answers.

* For the information of new members, the former name of the California Medical Association was "Medical Society of the State of California." With the consent of the Council, the organization here commented upon was permitted to use the former name of the State Association.—Ed.



COUNCIL, CALIFORNIA MEDICAL ASSOCIATION*

Front row (below): Morton R. Gibbons, San Francisco; William W. Roblee, Riverside; Howard Morrow, San Francisco; Oliver D. Hamlin, Oakland; Henry S. Rogers, Petaluma; Calvert L. Emmons, Ontario. *Second row:* Edward M. Pallette, Los Angeles; C. O. Tanner, San Diego; William H. Kiger, Los Angeles; Louis A. Packard, Bakersfield; Karl L. Schaupp, San Francisco. *Third row:* Frederick C. Warnshuis, San Francisco; Harry H. Wilson, Los Angeles; George H. Kress, Los Angeles; William R. Molony, Los Angeles; Clarence G. Toland, Los Angeles. *Fourth row:* Axcel E. Anderson, Fresno; Lowell S. Goin, Los Angeles; Alfred L. Phillips, Santa Cruz; George Reinle, Oakland; Carl R. Howson, Los Angeles; Charles A. Dukes, Oakland. *Fifth row (top):* Junius B. Harris, Sacramento; Hartley F. Peart, San Francisco; Mr. Hap. Hassard, San Francisco; Frederick N. Scatena, Sacramento.

When approached by agents to agree to render services at reduced fees, it is suggested that you pause and reflect before signing. In this connection read the resolution adopted by the San Mateo County Society and published in the Department of Public Relations in this issue.

Should you have signed such an agreement—shall we say inadvertently—you do well to cancel it at once. Never agree to be an underpaid, cut-rate employee of any corporation or company.

* * *

Applications for booth space for scientific exhibits at the Pasadena annual session will be reviewed and approved by the committee on February 23. Members desiring to present exhibits are requested to file their application with the State Secretary, accompanied by a brief description.

* * *

When engaging laboratory services, be sure that your consultant is a licensed physician specializing in radiology, pathology or bacteriology. "Licensed Physician," and not a "technician," for should you be involved in any action, your licensed physician becomes a competent expert, whereas the technician is extremely limited in his qualifications. You cannot afford to take the risk of referring patients to technicians for laboratory examinations.

* * *

Hospital insurance protection is now widely obtainable in California from organizations of approved standing. Urge your friends and employed groups to secure this protection. Hospital insurance at low premium rates will enable them to hurdle unpredictable hospital expenses. These policies are obtainable from three representative insurance organizations that confine their business to the writing of hospital insurance.

* Photograph was taken at the Council meeting held in Los Angeles on January 15, 1938, members standing on the steps of the west front of the Los Angeles County Medical Association Building. In addition to the councilors, others in the photograph are Doctors William R. Molony, Sr., George Reinle and Clarence Toland, and General Counsel Peart and Mr. H. Hassard.

The Council has deemed it inexpedient to attempt the passage of a Basic Science Law at the general election this November. This will be discussed at length in a future issue.

* * *

The following is taken from the January 15 issue of the *Journal of the American Medical Association.*

Don't Gamble with Gamble

Recently several physicians have paid $15 each for a listing of their names in an insurance medical directory; apparently they understood that they would be selected as medical examiners for certain insurance companies. This proposition was presented by one Mr. C. H. Gamble, representing the National Claims Statistical Bureau with offices in New York City and Atlanta, Georgia. In the event that one does not like the name of this organization, Mr. Gamble also represents the INsurOR INternationAL Association and the INsurOR Statistical Bureau, with offices reported to be in Washington, D. C., Chicago, Memphis, Oakland, California, and Dallas, Texas. Letters mailed to several of these addresses were returned marked "Name not in city directory." Inquiries sent to the Better Business Bureaus in these cities also failed to locate any such organizations. Although Mr. Gamble uses a number of addresses in a great many cities, evidently his office is "under his hat." Physicians throughout the length and breadth of the United States have been visited by Mr. Gamble. From South Carolina to California, from Illinois to Louisiana, from Florida, Texas and Arizona, have come complaints by physicians that the $15 paid out resulted in absolutely nothing—not even a press proof of their names. Apparently, Mr. Gamble has been too busy traveling to work up the rest of his business. Twice during 1937 THE JOURNAL published articles on insurance medical directories,1 pointing out the inadvisability of paying a fee for a listing in such directories. A resolution approved by the Judicial Council and adopted by the House of Delegates has condemned the listing of physicians in directories published by commercial concerns as unethical solicitation of patients. Officials of insurance companies have indicated clearly that commercial insurance medical directories are not used in the selection or appointment of physicians as examiners. Maybe some doctors have to pay for experiences of this kind, but reading THE JOURNAL is cheaper—and you get scientific articles also!

1 Medical Directories, J. A. M. A., 108:25B (Jan. 23), 1937; Why Pay a Fee? *Ibid.*, 109:23B (Sept. 4), 1937.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

The Social Aspects of Heart Disease

In the past six months 275,000 United States citizens have succumbed to heart disease.

In order to live comfortably and happily with your heart it is necessary to know what it can do, and how you can keep it in a healthy condition. Also, to be on good terms with it you should know something of its language so you will know when it is time to give it a rest. The heart takes up its burden many months before birth and continues its rhythmic contractions for many years, more or less, depending upon how well it is treated.

The heart beats 60 to 80 times a minute, 100,000 times a day, 3,000,000 times per month, 36,500,000 times a year. During a life span of sixty years the average contracts 2,000,000,000 times, and the only rest it gets is between contractions; the faster it beats, the less time it has to rest and restore energy.

In general, it rests about nine hours out of the twenty-four. Perhaps we should take that as a clue to follow in providing rest for the whole body. Every twenty-four hours the heart performs work equivalent to lifting a one-ton elevator to the height of eight stories. If the capillaries in the body were laid end to end they would extend four times around the earth and would fall only a few thousand miles short of reaching half the distance to the moon.

Yet, through this amazingly complex and elastic system of pipe-lines the heart pumps blood continuously against a pressure sufficient to raise a column of mercury to the height of 120 millimeters. The heart forces approximately five quarts of the body's blood through this system about once a minute, but it has a capacity to speed up and is able to pump up to sixteen quarts a minute during violent physical exertion.

A drop of blood can make its round trip through the circulatory system in twenty-two seconds. Each hour the heart swishes a barrel of blood through the body, seven and a half tons of blood a day. This appalling unceasing assignment of the human heart to work from long before birth to the instant of death is performed uncomplainingly and few of us are aware of its burden until we run upstairs too fast or until our physician wags his stethoscope at a mitral murmur.

San Mateo County Medical Society: Credit Bureau

If you fail to read this letter do not come to us in a few weeks with the remark, "I didn't know anything about it."

At the last meeting of the county medical society, a Medical Credit Bureau was established to operate through the office of the secretary. The object of this Credit Bureau is to obtain the names of chronic "dead-beats" who change from doctor to doctor, month in and month out, with the sole purpose of avoiding payment to anyone for the medical services variously rendered. A letter will be sent to you each month containing a list of names and addresses of such credit risks so that you may protect yourself and conduct business with these individuals either on a strictly cash basis or not at all. In order to make this possible, I am requesting each member of the Society to have their secretaries go through their files and make a notation of those patients, past or present, who are known "dead-beats." The success of this Credit Bureau depends entirely upon your coöperation. It can be of real service to you if you wish to make it so.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

The following motion was passed at the December, 1937, meeting:

"That the San Mateo County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the Industrial Accident Insurance Company, that a copy of this resolution be mailed to all members of the San Mateo County Medical Society and the National Automobile Insurance Company, and that any member accepting work from any insurance company entailing reductions of fees, splitting of fees or rebating of fees, be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the committee sees fit."

The necessity for this action grew out of the fact that certain members of this society and other societies have been approached by the National Automobile Insurance Company and asked to do work on a fee schedule less than the standard industrial fee schedule. In return a certain guarantee was supposed to be given. Please take note of the fact that any physician entering into such a contract with this or any other company is subject to disciplinary action (censure, suspension or expulsion from the Society).

Very sincerely yours,

(Signed): J. Garwood Bridgman, M.D.

Secretary.

Important

The antivivisectionist group is now waging a campaign to obtain the passage of an Initiative known as the "Dog Pound Initiative" at the November general election.

Should this Initiative pass, animal experimentation would be prohibited in this State and scientific research terminated.

Fortunately, there are those possessed of informed intelligence who recognize the value and need of scientific research through the means of controlled humane animal experimentation. They recognize the value of animal's contributions for the safeguarding of human lives and the prevention and treatment of disease.

This informed group opposes the campaign of the antivivisectionists. To make opposition effective for the defeat of this Initiative, they have organized the Society for the Protection of Medical Research. This society is endorsed by the California Medical Association, and its representations merit the support of everyone.

San Francisco, December 14, 1937.

Porter versus King County Medical Society Court Decision (58 Pac. (2nd) 367)

To the Secretary:—In reply to your inquiry of December 9, in regard to the above case, the essential facts are as follows:

It is a Washington case cited by the Supreme Court of that state. The decision was to the effect that the King County Medical Society acted within its powers in adopting a by-law calling for the expulsion of any member engaging in contract practice. The Washington court said that the constitution and by-laws of a medical society constitute a contract between the members of the society enforceable in the courts, if not immoral or contrary to public policy or the law of the land. All physicians who were members of the King County Medical Society were required to obey the by-laws of the society or subject themselves to the penalty of expulsion. The court stated that it was not material how selfish or unselfish the objects of the medical society may be. Whether the by-law relating to contract practice was just or reasonable or wise, was a question of policy which concerned only the medical society and its members.

The foregoing case is discussed in the *Journal of the American Medical Association* for April 3, 1937, at page 1211.

111 Sutter Street.

Very truly yours,

Hartley F. Peart.

COMPONENT COUNTY MEDICAL SOCIETIES

RIVERSIDE AND SAN BERNARDINO COUNTIES

A joint meeting of the Riverside and San Bernardino County Medical Societies was held at the California Hotel in San Bernardino on Tuesday, January 4. Dinner was served at 7 p. m.

The meeting was called to order by President Delbert B. Williams at eight o'clock. About seventy-five members and guests were present.

The applications for membership of Dr. Mildren Van Cleve of Redlands and Dr. Lowell L. Emmons of San Bernardino were favorably voted upon.

The speakers were then introduced in the following order: Calvert L. Emmons, District Councilor; W. W. Roblee, President-Elect of the California Medical Association; Frederick C. Warnshuis, Secretary-Treasurer of the California Medical Association.

Each speaker brought an important message to the societies.

Following a round-table discussion the meeting adjourned at ten o'clock. ARTHUR E. VARDEN, *Secretary.*

SACRAMENTO COUNTY

The following officers have been elected to serve the Sacramento Society for Medical Improvement for the year 1938: Dave Dozier, president; W. J. Van Den Berg, vice-president; G. E. Millar, secretary. Board of Directors, Dave Dozier, W. J. Van Den Berg, M. Azevedo, Frank Lee, H. Schluter, Max Isoard, H. M. Kanner, Cordes Ankele, and E. S. Babcock. Delegates, F. MacDonald, Raymond Wallerius, and H. M. Kanner. Alternates, W. Pollock, Paul Guttman, and Ralph Teall.

The following committees were appointed:

Public Relations—W. J. Van Den Berg (chairman), Paul Christman, J. T. Vance, Hugh Carmichael, and J. Mullen.

Banquet Committee—E. S. Babcock (chairman), Wayne Pollock, and H. Saverien.

Program—Cordes Ankele, D. Saeltzer, and L. Ruddy.

Legislative Committee—F. N. Scatena (chairman), Max Isoard, and R. Soutar. G. E. MILLAR, *Secretary.*

SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms, Stockton, on January 6, President John Blinn presiding. After the reading of the minutes Doctor Blinn installed the new officers for the year 1938 and turned the gavel over to the president-elect, Dr. A. C. Boehmer.

The petition of Doctor Schwing of Standard was acted on favorably and Doctor Schwing was declared a member. Petitions for affiliation to the San Joaquin County Medical Society were received from Doctors Julius Schreiber and Charles Martin, and these were referred to the Admissions Committee for investigation.

A letter from Doctor Anderson, Councilor for this district, was read and Doctor Van Meter made a motion, seconded by Dr. Dewey Powell, that the San Joaquin County Medical Society go on record as not at this time favoring the use of California Medical Association funds for attempting to secure signatures and pass the Basic Science Law, but that all the energies of the California Medical Association be directed against initiative measures which are threatened to be placed on the ballot against organized medicine. This motion was carried.

Dr. Dewey Powell read the following eulogy to the memory of Doctor Rixford of San Francisco.

"Last week-end the daily press brought us the sad news of the death of a great man, an outstanding member of the medical profession. Dr. Emmet Rixford of San Francisco had passed away in Peter Brent Brigham Hospital in the city of Boston. To all of us this news brought a keen sense of the great loss suffered by the medical profession, and to many of us it brought a keener sense of a personal loss of a revered teacher and a valued friend.

"Few men have been endowed with the great capacity and tremendous physique of Doctor Rixford. His seventy-three years were full of a great service rendered to the profession and to his fellow citizens. A remarkable surgeon, gifted with a sound sense of balance and good judgment together with unusual technical skill, he took great satisfaction in sharing his knowledge and tremendous experience with his many students, whom he loved to teach. He never ceased being a student himself, and his interest in and sponsorship of the Lane Medical Library is one of the most important reasons for the outstanding position of that library today.

"On numerous occasions throughout the years, Doctor Rixford has been the guest of this San Joaquin Medical Society, and the occasion of those visits stand out as important landmarks in our scientific programs. It seems, therefore, Mr. President, in view of the facts just recited, as well as the most important fact of all, that we are honored in having as one of our fellow members Doctor Rixford's son, Dr. Henry Rixford, that we should on this occasion pay a sincere and humble tribute to the memory of this great surgeon and teacher who has passed to his eternal reward.

"I would, therefore, move, Mr. President, that the secretary of this society convey to our fellow member, Dr. Henry Rixford, our sincere sympathy in the passing of his father, and that when this meeting adjourns that we do so by standing in silence, facing the west, for one minute in honor of our departed friend."

This motion was seconded by Doctor McGurk, and the motion was carried.

Dr. C. A. Broaddus announced that the final meeting of the Postgraduate Committee would be held on January 17 and that a dinner would be held at the Yosemite Club at 7 p. m.; and that there would be a clinic at the Medico-Dental Building, beginning at 5 p. m. on that same day. Dr. C. V. Thompson made a motion that the supper meetings be continued for the year 1938, these meetings to be on the same day and to precede the regular meetings. This motion was seconded by Doctor Blinn, and the motion was carried.

The paper of the evening was presented by Doctor Emge, professor of obstetrics and gynecology of Stanford University. The subject of his paper was *Cancer of the Female Genital Tract with Treatment.* This was illustrated with lantern slides and was very instructive.

There being no further business to come before the Society the meeting was adjourned at 10:30 p. m. in honor of Dr. E. Rixford. G. H. ROHRBACHER, *Secretary.*

SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held in the banquet room of the Benjamin Franklin Hotel on Wednesday, December 22, 1937, and was called to order by President Frank Gregory.

A letter from the California Medical Association, concerning proposed revisions to the Federal Food and Drug Laws, was read and a petition, which had been prepared by order of the Board of Directors, was presented, approved, and signed by all members present. A copy of the petition is attached to the minutes.

The Secretary then read a letter from the San Joaquin County Medical Society, concerning fee splitting and fee reduction with industrial accident insurance companies. The following motion was made by the Secretary:

"That the San Mateo County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the Industrial Accident Insurance Company; that a copy of this resolution be mailed to all members of the San Mateo County Medical Society and the National Automobile Insurance Company; and that any member accepting work from any insurance company entailing reduction of fees, splitting of fees, or rebating of fees, be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the committee sees fit."

The above motion is a verbatim copy of that passed by the San Joaquin County Medical Society. The motion was seconded and unanimously passed.

The Secretary read a letter he had received from the California Medical Association, concerning the United Hospital Service of the Physicians' Life Insurance Com-

pany. It was emphasized that this organization was not authorized by the California Medical Association.

The Secretary announced that the Board of Directors had approved the establishing of a Medical Credit Bureau to operate through the office of the secretary of the Society, whose function it would be to send a letter to every member of the Society once a month, containing names of patients who are known to one or more members of the Society as definite credit risks. This recommendation, on the part of the Board of Directors, was unanimously approved.

Announcements were made of the following new members: Doctors Meyerfeld, Richards, Eliason, and Hanson. Doctors Eliason and Hanson, who were present, were introduced and given copies of the constitution of the San Mateo County Medical Society.

The Secretary announced that in the future if dinner reservations were definitely made and not canceled prior to the day of the meeting, and the member did not attend the meeting, he will be charged for the dinner, nevertheless.

The name of Dr. Gerald F. Fairbairn was read as a new applicant.

Dr. Kirk H. Prindle was next introduced, and he presented a very interesting case of hand injury followed by local and general septic infection with recovery. Following discussion of this case, a four-reel film, prepared by Davis and Geck, *Traumatic Surgery of the Extremities,* was shown. Following the showing of the film, an enlightening discussion was led by Doctors Prindle, Hoag, and Cleary.

The names of the following duly elected officers for the coming year were announced by the chairman: Hartzell H. Ray, president; N. D. Morrison, vice-president; J. G. Bridgman, secretary-treasurer. Board of Directors: Olin M. Holmes (1937-1939), Frank S. Gregory (1938-1940), Carl Benninghoven (1938-1940), Harvey H. Whitney 1938-1940), Robert F. Monteith (1938-1940).

J. G. Bridgman, *Secretary.*

SANTA BARBARA COUNTY

The annual banquet of the Santa Barbara County Medical Society was held on January 10, with our newly installed president, Dr. E. J. Lamb, presiding. Other officers installed at the meeting were: Dr. W. H. Johnston, president-elect; Dr. J. Jerome Rupp, secretary.

The retiring president, Dr. Irving Wills, received congratulations for his splendid record, and everyone (the incumbent not excepted) regretted that a change of residence necessitated Dr. William H. Eaton's resignation as secretary-treasurer, an office he has filled most faithfully for many years.

Brief talks were made by Mr. Patrick J. Maher, Mayor of Santa Barbara, Mr. Paul G. Sweetser, President of the Santa Barbara County Bar Association, and Assemblyman A. W. Robertson. Mr. Charles A. Storke offered free facilities of radio station KTMS for the dissemination of health information.

Dr. Eugene Kilgore of San Francisco was the speaker of the evening, and gave a most interesting and detailed exposition. He deplored the prospect of socialized medicine. He cited an alarming example of the ease of obtaining endorsements to a program detrimental to the endorsers and again brought to attention that the quality of medical care was as important as the distribution of that care and that State medicine would be controlled by a political group concerned mainly with distribution.

In the business meeting which followed, Doctors Arthur D. Bissell, James Dalton, and Sheldon Payne were elected members of the Society by unanimous vote.

Jerome Rupp, *Secretary.*

VENTURA COUNTY

The annual meeting and election of the Ventura County Medical Society was held at the Saticoy Country Club on December 14, 1937.

The following communications were read:

From the American Medical Association, Bureau of Medical Economics, requesting a fee schedule.

From Dr. Ray B. McCarty, calling attention of anyone interested in giving a surgical paper at the next meeting of the California Medical Association, and that they should present their requests to him.

From the State Secretary's office in regard to the Federal Food and Drug Laws; the Peter's resolution, and the letters from the State Secretary's office in regard to this resolution; also a letter from Dr. E. S. Kilgore in regard to the same resolution.

A copy of the resolution was passed by the San Joaquin County Medical Society at their last meeting.

Doctor Osborn made a motion, seconded by Doctor Manning, that the Ventura County Medical Society be placed on record as unalterably opposed to fee splitting, reduction of fees, or rebating of fees to the Industrial Accident Insurance Company, and that a copy of this motion be mailed to all members of the Ventura County Medical Society and the National Automobile Insurance Company, and that any member accepting work from any insurance company entailing reductions of fees, splitting of fees, or rebating of fees, be brought before the Society for such disciplinary action as the Society sees fit. The motion was unanimously carried.

Doctor Smolt made a motion, seconded by Dr. Sterling Clark, that the Peters resolution be tabled. The motion was carried.

Doctor Osborn made a motion, seconded by Doctor Homer, that the Secretary be instructed to communicate with our national senators and representatives and express a desire of this body for more stringent revision of the Pure Food and Drug Laws. The Secretary was instructed to arrange for a meeting with Doctor Udo Wile.

The following were unanimously elected to membership in the Society. Dr. G. H. Arnold, Moorpark; Dr. W. N. Nelson, Fillmore; and Dr. C. R. Wylie, Ventura.

Dr. F. H. Garrett of the Camarillo State Hospital, Camarillo, was unanimously accepted as a transfer from the San Bernardino County Medical Society.

A rough plan for prepaid medical care to groups under a common employer was presented by Doctors C. Smolt, S. Clark, and Morrison. After a prolonged discussion, Dr. Coffey made a motion, seconded by Doctor Osborn, that the Ventura County Medical Society go on record as favoring some such plan as presented, and that the present committee be regularly appointed to draw up a complete plan to be presented before the Society as soon as possible. The motion was carried. Doctor Osborn made a motion, seconded by Doctor Homer, that a vote of thanks be given to the present committee (Doctors Smolt, S. Clark, and Morrison) for the work they have done in outlining this plan. The motion was carried. Doctor Homer made a motion, seconded by Dr. G. Clark, that the committee be given power by the Society to contact the interested groups. The motion was carried.

The following members having no opposition, were unanimously elected to office for the coming year: G. C. Coffey of Ventura, president; W. F. Mosher of Ventura, vice-president; A. A. Morrison of Santa Paula, secretary-treasurer; A. A. Morrison, alternate.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (14)

Alameda County

Maurice L. Horwitz — Elwood W. Lyman
Edward J. Jackemy — Ernest W. Page

Monterey County

William C. Johnson

Placer County

Christian B. Pedersen

San Bernardino County

Lowell L. Emmons — Benedict D. A. Miano

San Francisco County

Frederic A. Fender — John J. McKay, Jr.
Francis Foster

San Joaquin County

Julius Schreiber

Santa Cruz County

Anthony George Badami

Yolo-Colusa-Glenn County

W. J. Blevins, Jr.

Transferred (8)

Charles S. Ambrose, from Los Angeles County to Tulare County.

Herbert C. Archibald, from Alameda County to Monterey County.

Robert D. Dunn, from San Francisco County to Santa Clara County.

Floyd I. Hohnstein, from Alameda County to Napa County.

Charles W. Leach, from Mendocino County to Yolo-Colusa-Glenn County.

Arthur H. Rice, from San Francisco County to Yolo-Colusa-Glenn County.

Eberle K. Shelton, from Santa Barbara County to Los Angeles County.

Paul A. Werthmann, from San Joaquin County to Merced County.

Resigned (5)

H. A. Brown, from Alameda County.

Thomas G. Dabney, from Alameda County.

Henry Meyer, from San Francisco County.

Harold I. Sipman, from Alameda County.

Charles G. Wharton, from Los Angeles County.

In Memoriam

Gatchell, Willis LeForrest. Died at Stockton, December 31, 1937, age 83. Graduate of Bowdoin Medical School, Brunswick, Maine, 1882. Licensed in California in 1900. Doctor Gatchell was a retired member of the Butte County Medical Society, the California Medical Association, and the American Medical Association.

✝

Heffernan, William T. Died at San Diego, December 30, 1937, age 73. Graduate of the Medical College of Ohio, Cincinnati, 1889. Licensed in California in 1900. Doctor Heffernan was a member of the Imperial County Medical Society, the California Medical Association, and the American Medical Association.

✝

Howell, Edgar Henry. Died at San Francisco, December 30, 1937, age 54. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1907, and licensed in California the same year. Doctor Howell was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

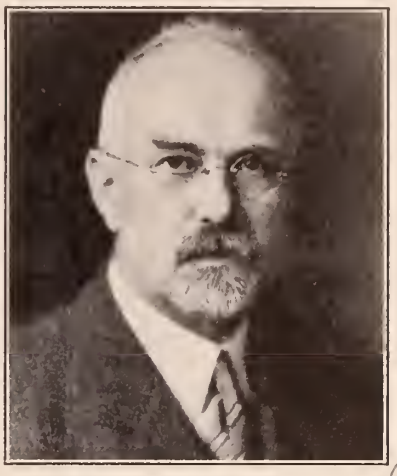
✝

Rixford, Emmet. Died at Boston, Massachusetts, January 2, 1938, age 72. Graduate of Cooper Medical College, San Francisco, 1891. Licensed in California in 1892. Doctor Rixford was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Seawell, James Walter. Died at Healdsburg, December 26, 1937, age 58. Graduate of the University of California Medical School, San Francisco, 1901, and licensed in California the same year. Doctor Seawell was a member of the Sonoma County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY



Emmet Rixford
1865–1938

The passing of Emmet Rixford at seventy-two years of age removes one of the great figures in the medical history of California and the West. He had been a tower of strength in the affairs of this Society, having served as its president in 1905 and again in 1924, a tribute to those innate qualities which won for him the respect and admiration of his associates. He continued in the service of the Society as a member of its Board of Directors to the very end.

As his father before him was a distinguished pioneer in the horticultural development of the State, so he early became a surgeon of distinction in the local profession and in the faculty of Cooper Medical College. At the incredibly young age of thirty-three, he was made professor of surgery, a position held by him for thirty-two years, when he was reluctantly retired to the emeritus group of Stanford University Medical School. His recognition and description of an unrecorded disease, coccidioidal granuloma, had been written two years earlier. By 1905, he had won nation-wide eminence and recognition as vice-president of the American Surgical Association, whose president he became in 1928.

In his home community he maintained an active interest in civic affairs, serving for many years as one of the governors of the Commonwealth Club. As the accompanying sketch of his life's story indicates, no matter what field of endeavor he entered, whether the practice of his profession, the exploration of mountainous wilds, the growing of beautiful roses, or the competition of yacht racing, his ability carried him to undisputed leadership. His courage proverbial, his composure under stress unequaled, his mind quick to grasp the new and worth while and able to retain it for instant use when necessary, all combined to make him a brilliant teacher, who profoundly influenced many generations of students, and a surgeon of accomplishment, whose service and advice were sought by layman and professional colleague from far and near.

In the grievous loss that this Society, this community, and this nation have sustained by the death of Emmet Rixford, it is fitting that we as fellow directors of the San Francisco County Medical Society place on record our sincere appreciation of his incomparable service to his fellow men, and our deep sense of personal loss at his passing, and that we direct the secretary of the Society to transmit a copy of these resolutions to his sorrowing family.

✝ ✝ ✝

WHEREAS, The Almighty Ruler of the Universe, in His Infinite Wisdom, has seen fit to remove from our number one whom we long loved and cherished—Dr. Emmet Rixford; and

WHEREAS, Through many years of professional and social acquaintance, we had learned to know him as one who exhibited the highest qualities of gentlemanly conduct, humanitarian spirit, and intelligent judgment; and

WHEREAS, His attitude toward his fellow practitioners in his chosen profession was ever courteous and helpful, especially to the younger man in medicine; and

WHEREAS, Through his long years of service as a teacher of the medical arts and sciences he had enlightened a large group of capable students who, inspired by his precept and example, have carried the lessons he taught throughout our state and nation; and

WHEREAS, His untimely passing has taken from us a kindly soul steeped in the love of his fellow man, ardently alive to the suffering of the sick, whose example has elevated the principles and practice of medicine in our community, be it

Resolved, That the California Medical Association, with heartfelt sorrow, record the death of this beloved friend and associate, whose kindly countenance and abundant wisdom have for so long graced and enlightened our meetings; and be it further

Resolved, That a copy of these resolutions be properly indited in the records of the California Medical Association, and that a copy of the same be transmitted by the secretary of our society to his bereaved family, with our deepest sympathy.

O. D. HAMLIN, M.D.
C. A. DUKES, M.D.
C. G. TOLAND, M. D.

* * *

Emmet Rixford, professor of surgery, emeritus, at Stanford University Medical School, one-time intimate associate of Dr. Levi Cooper Lane, died at the Peter Bent Brigham Hospital, Boston, January 2, of cardiac failure incident to an old coronary thrombosis, four days following an operation upon the bladder.

He was born in Bedford, Quebec, of American parents, who journeyed to California by way of Nicaragua in 1867, where the father became one of the State's distinguished pioneers, being directly responsible for the introduction of the Smyrna fig, and several hardy varieties of citrus fruits.

The son, Emmet, was graduated from the University of California in engineering in 1887, but was promptly diverted into medicine, taking his degree from Cooper Medical College in 1891. Together with Stanley Stillman, he became Dr. Levi Cooper Lane's assistant, later traveled as a graduate student in Eastern and European clinics, was named adjunct professor of surgery at Cooper Medical College in 1893, and professor of surgery in 1898. When Cooper Medical College was taken over in 1909 by Stanford University as its medical department, he continued as professor of surgery and chief surgeon on the Stanford service at the San Francisco County Hospital, where he served continuously as visiting surgeon for thirty-six years. His Thursday morning "colloquia" were attended by numerous surgeons, and many generations of students, who came to be instructed, as well as entertained, by this master of surgery. Resourceful and rapid in operating, quick and decisive in judgment, equipped with a mind abundantly laden with information at his immediate command, he made a brilliant teacher at the operating table.

His activity as an operator bridged the period between antiseptic and aseptic surgery, between drainage and non-drainage of wounds, but his facile mind quickly accepted and improved upon the rapidly advancing developments in surgery. He early insisted upon a bacteriologic and pathologic study of his operative specimens, and was himself an excellent surgical pathologist. He was one of the first on this coast to employ the x-ray and with it to locate accurately, because of his engineering training, a foreign body in the brain, permitting its successful removal by his associate, Dr. Stanley Stillman.

His engineering training made him particularly adept also in the understanding of fractures and dislocations, and a number of his papers dealt in original manner with the mechanics of the production and treatment of the green-stick, buckling, torsion, and flexion fractures. His first paper in 1894 dealt with the symptoms and diagnosis of tuberculous disease of the joints. Subsequent papers covered the gamut of general surgery: the treatment of hernia, of goiter, of pancreatitis, of renal calculus, of gallstones, of cancer in many sites; the rôle of industrial trauma in the development of cancer; the early history of the Pacific Coast medical schools and journals; and biographies of Cooper, Lane, and Huntington, pioneer master surgeons of California.

Quick to recognize in one of his early patients from the San Joaquin Valley that he was dealing with an unusual infection, he sent material to Professors Welch and Gilchrist of Johns Hopkins for further intensive study, which led subsequently to the recognition and description (by Rixford and Gilchrist in the first volume of the Johns Hopkins Hospital Reports, 1896) of a new disease, coccidioidal granuloma, also known as the San Joaquin Valley disease.

National recognition of his ability came early: vice-president of the American Surgical Association in 1905, he became its president in 1928; he was twice president of the San Francisco County Medical Society; a founder of the Pacific Coast Surgical Association, he became its president in 1932; long a member of the Society of Clinical Surgeons, he attended most of its meetings and accompanied its members on all but the last of its foreign tours. He held membership in the American College of Surgeons, in the Internationale Societé de Chirurgie, the California Academy of Medicine and the California Academy of Science. He helped organize the California Horticultural Society and was its vice-president during the past year. In 1928, at the request of Dr. Harvey Cushing, he served for three weeks as surgeon-in-chief *pro tem.*, of the Peter Bent Brigham Hospital in Boston, a significant honor shared on other occasions, among others, by such distinguished surgeons as Sir Charles Ballance, Professor Foerster of Breslau, Professor Gask of London, Professor Giertz of Stockholm, Professor Leriche of Strassburg, Sir D'Arcy Power of London, Professor Putti of Bologna, Sir Herbert Stiles and Sir David Wilkie of Edinburgh, Dean Lewis, Evarts Graham, Allen Whipple, and George Heuer of America.

A lifelong and paramount interest was the Lane Medical Library, whose completeness and present position as one of the great medical libraries of the country are entirely due to his efforts. It was he who prevailed upon his classmates in 1891 to purchase a two-volume atlas of skin lesions, which really formed the nucleus for the later development of the present library. It was he who journeyed to the Surgeon-General's library on several occasions, found duplicates of important volumes, and was permitted to box and send them to San Francisco. It was through his perspicacity and friendship with Doctor Jacobi of New York that he secured over 24,000 volumes of the early medical journals and greatly prized Paris theses which were found duplicated when the New York Academy and New York Hospital combined their libraries. The Lane Library, though named at his suggestion in honor of his chief, will be an enduring monument to his memory.

Although a distinguished scholar in his chosen field, Doctor Rixford's great charm lay in his extraordinary breadth of knowledge outside his professional calling. An authority on land snails, he possessed one of the most complete collections in California. His achievements as an indefatigable mountain climber are forever commemorated by the designation of a 13,000-foot peak in the Kearsarge Range of the Southern Sierra as Mount Rixford. His reputation as an authority on rose culture was nation-wide. As skipper on the Sloop *Annie*, brought around the Horn in the seventies, he won numerous races on San Francisco Bay, and was at one time designated Commodore of the Fleet. When *Annie's* day was finally done, she was reverently burnt at sea. When the earthquake and fire of 1906 rendered many homeless, he was made chairman of a relief fund to help destitute physicians. The Pacific Union, Bohemian, and Commonwealth Clubs of San Francisco claimed him as a member.

He is survived by his wife, Mrs. Louise Campbell Rixford; two sisters, Mrs. Geneve Rixford Sargeant, an artist, and Mrs. Caroline Byrd; a brother, Loring Pickering Rixford; a daughter, Mary Campbell; and three sons, Loring, Dr. Henry Covington Rixford, a surgeon of Stockton, California, and Dr. Emmet Lane Rixford, a surgeon in San Francisco.

His was an unusually active and useful life, full of zest for enjoyment, mingled with constant devoted service to his fellow men. No man, however poor, was ever denied the privilege of his skill. His service to the destitute sick of San Francisco is incalculable. When payment was possible, his requests were moderate. "No man whose life I have saved shall mortgage his remaining existence to me." He builded for himself an enviable monument of gratitude in the hearts of his fellow men. Many mourn his passing, few shall see his like again.

EMILE HOLMAN.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS.....President
MRS. FRED ZUMWALT Chairman on Publicity

State Auxiliary Notices

Official Notice of State Board Meeting.—Mrs. Hobart Rogers, President of the Woman's Auxiliary to the California Medical Association, announces a meeting of the officers and Board of Directors to be held in Los Angeles on February 23, 1938. Official announcement will be received by members of that body through the mails.

Mrs. B. H. Sherman, 1622 North Fairfax Avenue, Hollywood, Chairman of the Library Board of the Woman's Auxiliary, will have received, when this notice goes to press, the designs for the Book Plate Contest, as all entries must have been in the mail on or before February 5. By the middle of March the judges will probably have made the awards and the names of the winners been known. As soon as they are sent in, the names will be published along with a description of their designs.

Component County Auxiliaries

Alameda County

On Friday, January 21, the Woman's Auxiliary to the Alameda County Medical Society will hold their first meeting of the year at the Claremont Country Club at twelve o'clock. Mrs. Thomas Clarke will be hostess for the informal reception preceding the luncheon. Mrs. Richard A. Young will be chairman of the day.

Honoring us will be Dr. Chauncey Leake, professor of pharmacology and materia medica at the University of California, who will address us on *Drug Foolishness.*

Mrs. Hobart Rogers, State President and a member of our Auxiliary, will also be an honored guest. Her subject will be *Your Auxiliary and Mine.*

MRS. GRANT ELLIS,
Chairman of Publicity.

Fresno County

On December 7, 1937, the Woman's Auxiliary to the Fresno County Medical Society was honored by a visit from the state president, Mrs. Hobart Rogers, and the corresponding secretary, Mrs. Charles Hall. Our business meeting was preceded by a delightful dinner at the California Hotel. The table, decorated by Mrs. B. F. Walker, was quite in the Christmas spirit. Along the table were red candles with the fruit of strawberry trees around them, and in the center of the table a round centerpiece of the fruit.

After the dinner there was a short business meeting. This was held in the lounge of The University-Sequoia Club. We then enjoyed a talk by Mrs. Rogers, delivered in her usual delightful manner, in which she spoke of the ideals and aims of the Auxiliary. Mrs. Hall also talked to us for a few minutes. The meeting then adjourned.

MRS. C. P. DOANE,
Chairman of Publicity.

Los Angeles County

Taking the place of the December luncheon meeting of the Woman's Auxiliary to the Los Angeles County Medical Association, a Christmas tea was given for the members on December 14 by Mrs. Eliot Alden, president, at her home, with members of the Board assisting.

Guests of honor were Mrs. Clifford Andrews Wright, President-Elect of the Woman's Auxiliary to the California Medical Association, and Mrs. James F. Percy, a past president of the Los Angeles County Auxiliary.

The Philanthropy Committee received at this time contributions for the Christmas baskets which were distributed to the families of needy doctors in Los Angeles County.

MRS. ROBERT L. CARROLL,
Corresponding Secretary.

Riverside County

The Woman's Auxiliary to the Riverside County Medical Society held an interesting meeting in December at the home of the president, Mrs. T. A. Card, on Aurora Drive.

The Auxiliary is trying to get a welfare footing, probably a reading and game room, in the poverty-stricken Mexican quarter, known as Casa Blanca. The Rev. Alec Trujillo, pastor of the Presbyterian Mission in this district, reviewed some of the social service needs. The principal of the school in this section outlined plans for a homemaking project which she hopes to establish, by means of which children of the school will prepare their own cafeteria lunch. Christmas songs by four Mexican girls completed the program.

About fifty members and guests were present for the social hour, during which refreshments were served. Assisting hostesses were Mesdames A. W. Miller and S. H. Keller.

MRS. H. J. WICKMAN,
Corresponding Secretary.

Sacramento County

An elaborate Christmas party was given the Woman's Auxiliary to the Sacramento Society for Medical Improvement by its Board of Directors in the home of Mrs. F. N. Scatena on Tuesday, December 21.

The evening was given over entirely to entertainment which included a musical program and a dramatic reading.

The Scatena home was beautifully decorated with Christmas trees, laurel wreaths, holly berries, and miniature Christmas scenes.

Some of the guests played bridge during the evening and prizes were distributed to the winners.

Gifts from a large Christmas tree closed the program for the evening, followed by refreshments.

Members of the Board of Directors are: Mesdames F. N. Scatena, Dave F. Dozier, William Van Den Berg, George Briggs, Orrin Cook, Leo Farrell, Hilding Johnson, Norris R. Jones, Frank Krull, Frank MacDonald, and James Yant.

MRS. H. CARMICHAEL,
Chairman of Publicity.

Santa Barbara County

The Santa Barbara County Woman's Auxiliary to the Santa Barbara County Medical Society was entertained at tea on the afternoon of November 23 by Mrs. Franklin R. Nuzum at her home in Montecito. This was the annual membership tea of the Auxiliary. The wives of all doctors and internes who are members of the county medical society were invited.

The Auxiliary held no December meeting.

MRS. H. E. HENDERSON,
Chairman of Publicity.

San Diego County

The Woman's Auxiliary to the San Diego County Medical Society met at the Men's University Club for its regular monthly luncheon on January 11.

Dr. James C. Anders, formerly a medical missionary in West Africa and head of one of the hospitals there, gave an interesting talk on *The Life and Customs of the Yoruba Tribe in West Africa.* His talk was illustrated by moving pictures which he had taken while residing in Africa.

Mrs. W. B. McGee gave a short review of an article from *Hygeia.* The very colorful decorations were provided by Mrs. E. H. Christopherson and Mrs. Otto Marsh.

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

San Francisco County

The first general meeting of 1938 will be held at the Auxiliary headquarters, 2180 Washington Street, on Tuesday, January 18, 1:30 p. m., with the president, Mrs. Hans Barkan, presiding. Dr. Mary H. Layman, a member of the Board of Directors of the Motion Picture Research Council, will address the members and guests on the *Effect of Motion Pictures on Children.*

The round-table discussions, under the leadership of Mrs. Julius Sherman, will continue during the spring on the first and third Mondays at 1:30 p. m. On Monday afternoon, January 3, the study group visited the Lane Library, founded by the late Dr. Emmet Rixford, to see the manuscripts of antiquity relating to the history of medicine.

Mrs. Howard B. Dixon, who was appointed by the president as the official representative of the Auxiliary to the Woman's Club House Association for the World's Fair of 1939, has been active in her duties attending committee meetings and arranging matters of interest for the Auxiliary. The clubhouse will be located on the fair grounds, and the members of the Auxiliary will be eligible to membership in the Association.

Responding to a request from the Parent-Teachers Association for a speaker from the Auxiliary, Mrs. A. S. Musante, a member of the Auxiliary Board of Directors, graciously addressed a large group at the General Pershing School on Tuesday, January 4, on the *Effect of Movies and Radios on Children.* Mrs. Musante is vice-president of the Motion Picture Council of San Francisco County.

Mrs. Harry R. Oliver,
Publicity Chairman.

Pasteurized Milk.—The term "pasteurization," or pasteurized, refers to the process of (1) heating every particle of milk to a temperature of not less than 142 degrees Fahrenheit, and (2) holding it at such temperature for not less than thirty minutes in (3) an approved pasteurization apparatus. (4) Approval shall be limited to an apparatus which requires a combined recording and indicating thermometer temperature tolerance of not more than 1½ degrees Fahrenheit, as shown by official tests, and (5) such apparatus shall be properly operated, and (6) the indicating and recording thermometer charts shall both indicate a temperature of not less than 143½ degrees Fahrenheit continuously throughout the period the milk is held.

The term "pasteurization or pasteurized" also includes the process of heating every particle of milk to 160 degrees Fahrenheit and holding at that temperature or above for not less than fifteen seconds in apparatus of approved design and properly operated. Cooling to a reasonably low temperature (50 degrees or less, and maintained at that temperature until delivery) immediately following the heating and holding, in order to prevent the growth of organisms surviving pasteurization.

Subjecting milk to the pasteurization process defined above will kill the bacilli of typhoid fever, the paratyphoid fevers, diphtheria, tuberculosis, and the dysenteries. It will also kill the streptococci of scarlet fever and septic sore throat, the micrococcus of undulant fever, the virus of foot and mouth disease, and all other nonspore-bearing organisms with which milk may be contaminated. The determination of the thermal death point of pathogenic organisms by various investigators, together with past experience with the use of properly pasteurized milk, indicates very clearly that the thermal death point of these organisms is relatively low and that they are readily destroyed by proper pasteurization. Pathogenic organisms are considered to be of great public health significance, since they cause human disease.

When considering what is the most economical and practical way of safeguarding a city's milk supply, pasteurization, properly accomplished, is the only solution. It is indeed a pity that milk, which is such an excellent food, can be such an extremely dangerous one if not properly safeguarded. Milk is not only a good food for human beings but also a good food for certain types of disease organisms. The necessity for pasteurization becomes increasingly apparent when we consider these possibilities of transmission of disease through the agency of milk. Milk may, upon occasion, without our knowledge, come from cows infected with tuberculosis or undulant fever. This source of danger may be minimized by elimination of the infected animals from the producing herds on the basis of tests devised for this purpose. One question must assail us, for how many months had the now eliminated cows been infected with these diseases before they were detected and slaughtered?

To build a hypothetical case: Assuming that the producing herd had been freed of infected cattle. This offers no protection against such diseases as typhoid fever, diphtheria, and septic sore throat, because the pathogenic organisms causing these diseases may come from infected water supplies or from human carriers of disease.

It is self-evident that pasteurization should not be used to conceal slovenly methods of milk production nor relied upon to take the place of efforts to produce a high quality of milk. It is equally evident that pasteurization cannot be blamed for the results of its improper use.

Pasteurization, properly accomplished, means that each step of the process described in defining pasteurization is actually observed. Many elements, such as faulty equipment, and careless operation, which ignores pasteurization principles, conspire to defeat this term. Pasteurization with adequate regulation, by means of an accepted ordinance plus uniform and efficient inspection by the personnel in the local city or county health department, makes possible a safeguarded milk supply.—*Ohio Health News.*

Facts About Pneumonia.—Of all acute diseases pneumonia is the most prevalent and fatal. As a cause of death in the United States it now exceeds tuberculosis. It occurs in all climates and is prevalent in tropical countries as well as in cold countries. It is more prevalent in the northern states of this country than in the southern states. Pneumonia shows a decided season of prevalence, as it occurs more frequently in the winter and spring months. It attacks individuals of all ages, but its incidence is most marked in infancy and in extreme old age. It occurs more frequently among males and is more highly fatal in negroes. When it attacks individuals who are physically strong, recovery generally occurs. In individuals who are physically weak and who are suffering from other disabilities, pneumonia is more often fatal. Ordinarily, pneumonia does not appear to be contagious. The pneumonococcus organism does not thrive outside of man.

While the disease sometimes occurs in epidemics, it ordinarily shows little tendency to develop in individuals who may come into contact with cases. Such outbreaks as have been recorded have occurred in institutions, camps, on shipboard, and in places where overcrowding may occur. Pneumonia is epidemic when influenza and measles are epidemic. It seems to thrive when the individuals' resistance becomes weakened through attacks of other infections. One attack does not confer immunity. In fact, increased susceptibility is more often the rule. The disease occurs often among alcoholics and develops frequently following exposure to cold and accidents. It is often found as a complication of whooping cough, typhoid fever, and other infections. Overexertion, fatigue, and exposure are often contributory factors in the development of pneumonia. Overcrowding, indiscretions in eating and drinking, and other factors that are commonly associated with the development of common colds are constructive factors in pneumonia.

While progress has been made in the prevention of pneumonia through the use of certain biologics, the best general methods of prevention lie in the avoidance of dissipation, poor or insufficient food, lack of exercise, loss of sleep, worry, overwork, alcohol, common colds, fatigue, and excesses of all kinds. Sleeping with open windows, living in rooms that are not overheated, breathing air that contains a sufficient amount of moisture, frequent baths of moderate or cold temperature, and the general observance of the laws of hygiene, are all important in the prevention of the disease. Individuals who suffer from minor infections should be properly safeguarded against pneumonia. Recovery should be complete before exposure to stresses and strains that might lower individual resistance. Advances are being made in the development of effective procedures against pneumonia, and it is possible that practical measures applicable to general use may soon become effective.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

* * *

California State Dental Association, Stockton, April 4–6, 1938. C. E. Stabler, D.D.S., 1003 Medico-Dental Building, Stockton, General Chairman.

Pacific Coast Surgical Association, Los Angeles, February 22–25, 1938. H. Glenn Bell, M.D., University of California Hospital, San Francisco, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of February is as follows:

Thursday, February 3—KECA, 11:00 a. m., The Road to Health.
Saturday, February 5—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 10—KECA, 11:00 a. m., The Road to Health.
Saturday, February 12—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 17—KECA, 11:00 a. m., The Road to Health.
Saturday, February 19—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 24—KECA, 11:00 a. m., The Road to Health.
Saturday, February 26—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Resolution Against Special Contracts by Hospitals.—The following resolution was adopted by the Executive Committee of the Hospital Council of Southern California at a meeting held on January 11, 1938:

WHEREAS, Hospitals are constantly striving to balance budgets, and more often than not fail to balance their budgets;

WHEREAS, True costs studies show many published rates, particularly ward rates, less than cost;

WHEREAS, Insurance companies, corporations with medical departments, physicians doing group practice have asked or demanded special rates and in many cases succeeded in getting them;

WHEREAS, These rates are not founded on any social basis, but are preferential to those most able to pay full costs;

WHEREAS, Such policy of granting special rates to powerful companies has been thoroughly discredited, and branded as bad business ethics;

WHEREAS, Such policy not only is bad for hospitals, but also results in unfair competition in the profession of medicine also; be it therefore

Resolved, (*a*) That hospitals in this Council go on record as disapproving the practice of entering into special contracts at special rates.

(*b*) That hospitals in this Council recommend and urge all hospitals to grant no rates below their own published schedule, except to individual cases of merit, and to those patients after social service investigation proves such right.

(*c*) That a copy of this resolution be forwarded to the County Medical Association and to its members, assuring each high-class practicing physician that no secret agreements will place him at a disadvantage.

Associated Hospital Service of Southern California. The Associated Hospital Service of Southern California have opened offices at Room 528 Chamber of Commerce Building, 1151 South Broadway, Los Angeles, telephone Prospect 2579, and have entered into arrangements with Dr. L. B. Rogers, formerly superintendent of the Hollywood Hospital, to act as executive director of the new organization. Other officers are: R. E. Heerman, president; William H. Kiger, vice-president; Leonard K. Brown, secretary; Edward M. Pallette, treasurer. The hospitalization plan of the Associated Hospital Service of Southern California has been approved by the Los Angeles County Medical Association and is before the State Insurance Commissioner.

The following hospitals have become affiliated with the Associated Hospital Service of Southern California, as contracting hospitals, and have been inspected and certified by the State Department of Public Health: Alhambra Hospital, Alhambra; The California Hospital, Los Angeles; Cedars of Lebanon Hospital, Los Angeles; Foster Memorial Hospital, Ventura; Jared Sidney Torrance Memorial, Torrance; Las Campanas Hospital, Compton; Loma Linda Sanitarium and Hospital, Loma Linda; Long Beach Community Hospital; Mercy Hospital, San Diego; Methodist Hospital, Los Angeles; Mission Hospital, Huntington Park; Physicians and Surgeons', Glendale; Presbyterian Hospital, Olmsted Memorial, Lessee Hollywood Hospital; Riverside Community Hospital; San Pedro General Hospital; Santa Barbara Cottage Hospital; Santa Fe Hospital, Los Angeles; Santa Monica Hospital; Scripps Memorial Hospital, La Jolla; Seaside Memorial, Long Beach; St. John's Hospital, Oxnard; St. Joseph's Hospital, Orange; St. Luke's Hospital, Pasadena; White Memorial Hospital, Los Angeles; Hospital of the Good Samaritan, Los Angeles; Centinela Hospital, Inglewood.

Health Insurance Lecture Series.—Health insurance and medical sociology are to be made a special order of business by the University of California Medical School through a series of lectures dealing with many phases of these subjects.

The first lecture will come on February 2, when Dr. Paul Dodd will speak on the topic, "Cost of Medical Care." The other lecturers and lectures are as follows:

February 9, Dr. E. F. Penrose, Theory of Health Insurance; February 16, Dr. B. N. Armstrong, The Health Insurance Doctor in England, Denmark, and France; February 23, Dr. P. K. Brown, Health Insurance in the United States; March 2, Dr. A. H. Mowbray, Actuarial Principles of Insurance and Health Insurance; March 9, Dr. W. P. Shepard, the Physician's Place in the Community; March 16, Dr. H. A. Meyer, Health Insurance in Germany; March 23, Dr. J. B. Saunders, Health Insurance in Great Britain; March 30, Dr. T. H. Kelley, Organized Medicine and Health Insurance; April 6, Dr. E. S. Kilgore, The Relationship of Government to Medicine.

The lectures will be open to faculty, resident staff, medical students, members of the profession and all others interested, and attendance is expected from many parts of the State. They will be given in the auditorium of the University of California Extension Division at 540 Powell Street, San Francisco.

The series will be under the direction of Dr. Salvatore P. Lucia, and each lecture will be thrown open for free discussion at its conclusion.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

The Work of the State University.—The University of California Extension Division exists for the purpose of distributing the benefits of education as widely as possible. It traces its origin to a series of lectures on the tragedies of Shakespeare, inaugurated by the late Professor Charles Mills Gayley on October 10, 1891, almost a half-century ago. These lectures and others offered subsequently were of such popularity that in 1913 it became necessary to organize a division of the University to administer them. Since then the public response to this opportunity for self-improvement has steadily increased. In the year 1935–1936, throughout the State there were 1,981 class courses with 41,047 enrollments. During the same year there were 2,939 enrollments for instruction by correspondence, 123,490 people attended special lectures sponsored by the Extension Division, and an aggregate audience of 1,226,000 people observed 12,263 motion picture or stereopticon programs supplied to schools, clubs, and study groups in various parts of the State.

As these statistics indicate, the University of California is a vastly different kind of institution from the old cloistered universities. It continues, however, to offer technical and specialized instruction as did universities of another day. During regular sessions on its seven campuses last year, 23,000 men and women were in residence, and more than 4,000 additional attended summer sessions. But public universities in a modern democracy must be more than centers of higher learning. They must be clearing houses where the knowledge of the world is brought to bear upon the problems of the commonwealth, and where the public can find technical assistance and intellectual leadership. The University of California bears these responsibilities. It sponsors investigations, and publishes its findings in scores of different fields, from agriculture to medicine and from history and government to mining and civil engineering. The courses announced in this booklet are a part of the public service of the University of California. They help men and women to gain more from life.—From the brochure, "Lifelong Learning," Berkeley, December 20, 1937, Vol. 7, No. 21.

Second National Social Hygiene Day.—*Social Hygiene News* of December 1, 1937, prints the following letter from President Ray Lyman Wilbur of Stanford University:

A Letter From the President

Dear Friends and Members of the American Social Hygiene Association:

Syphilis is in the headlines, on club programs, on the screen, on the air, on bookshelves, on the public mind!

What next? Will the nation merely talk and not act? Will nearly twenty million people continue to suffer with syphilis and its twin peril, gonorrhea, and threaten other millions? Shall ye keep on letting 500,000 new cases of syphilis appear each year? Thousands more to become needlessly blind or crippled? Taxpayers to bear the burden of caring for the 10 per cent of inmates of mental institutions who are there because of preventable end-results of syphilis? Shall sixty thousand syphilitic babies be born each year?

Not if the Association's Antisyphilis Committee can summon support needed to rally the nation against these vicious and expensive diseases. Experience in other countries shows that these maladies can be checked. American medical science is competent to do its part. Syphilis and gonorrhea can be conquered if—

1. Everybody learns how dangerous they are.
2. Those infected are taught to seek treatment early.
3. Proper treatment is assured for all who need it.
4. Health departments and coöperating agencies are furnished with enough money and personnel to do what is necessary.

Surgeon-General Parran looks to this Association to lead the way in "telling all the people." Its National Antisyphilis Committee, headed by General John J. Pershing, is charged with this duty and is raising $500,000 required by the Association. The Second National Social Hygiene Day, February 2, 1938, will draw attention to a most tragic aspect of syphilis—its attack on young men and women.

Will you help? Your membership dues, with any additional contribution you can spare, mean much. And as a citizen, you can hardly afford to be without the *Journal of Social Hygiene*, the *Social Hygiene News*, and other up-to-date publications. We count on you for 1938!

Sincerely yours,

Ray Lyman Wilbur, M.D.

President, American Social Hygiene Association.

Examinations: American Board of Obstetrics and Gynecology.—The general oral, clinical, and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Application for admission to the June, 1938, Group A examinations must be on an official application form and filed in the secretary's office before April 1, 1938.

The annual informal dinner and general meeting of the Board will be held at the Palace Hotel, San Francisco, on Wednesday evening, June 15, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, will be the guest speaker, and the diplomates certified at the preceding days' examinations will be introduced individually. All diplomates are invited to attend the dinner meeting, and to bring as guests their wives and any persons interested in the work of the Board.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6), Pennsylvania.

Publicity Materials for Social Hygiene Day.—The following item from the December 15, 1937, *Social Hygiene News* indicates how educational campaigns should be arranged:

"The Association staff has been busy for several months on the designing and production of new and arresting publicity materials for general as well as Social Hygiene Day use.

"Notable among these is a long-needed display for the general public. Included in this set are eight texts which are illustrated with drawings and photographs. The set is recommended for clinics and health centers and other places where large numbers of uninformed persons gather. The price will be about $1.50 per set, postpaid.

"An easel cut-out is being produced for use on drug-store counters. Local health department or social hygiene society leaflets should be placed with the cut-outs to give information concerning early diagnosis and treatment and where these may be obtained. The cut-out was made especially small and attractive so that a maximum number of druggists, who might object to large displays, will be anxious to use them. These will be about $5 a hundred, with your own imprint on large orders.

"By special arrangement with the publishers of Thomas Parran's 'Shadow on the Land,' a special educational edition is being provided through the Association. Made to sell for $1 each, they are available in quantity at $9 per dozen and $65 per hundred. The text is identical with that of the $2.50 edition.

"A Press Book will be included with the special kit which is being prepared. Included will be four suggested 'spot news' stories, two editorials, and ten three-minute radio talks. Twenty-five 'spot' announcements for radio will also be available.

"A Social Hygiene Day poster is being produced. The design will also be carried out in several sizes. A stereotype which can be inserted in the regular advertising of department stores, banks, and others will be provided on request.

"The Metropolitan Life Insurance Company offers splendid coöperation. A full-page advertisement will appear in all leading magazines for February. Also a large card, 'Protect Youth from Syphilis,' has been prepared and is offered for use in developing a store window display.

"The New York State Department of Health is offering its electrical transcriptions and may be able to release a new motion picture 'trailer' in time for general use on February 2.

"Look in the October *Journal of Social Hygiene* for recent bibliography.

"An appealing twenty-four-sheet outdoor billboard poster urging blood tests for expectant mothers is available for use in your community. Arrange for free space with your local outdoor advertising company. The Association can provide these posters at $1.50 each. Included, without extra cost, is a narrow strip announcing Social Hygiene Day to be pasted across the larger display. Hundreds of billboards will carry this poster during January."

Community Program for Combating Syphilis and Gonorrhea.*—Details of a modern program for combating syphilis and gonorrhea will differ from city to city in accordance with the size and character of each, but principles based on accepted facts should be identical wherever applied.

Briefly, a community program reduces itself to a few basic factors. These are education, case finding, and treatment.

Through education and various types of publicity, popular support can be rallied for the city's fight on syphilis and gonorrhea and the conditions which favor their spread.

Case finding receives impetus through well-directed publicity. Places for diagnosis and treatment should be made familiar to all, and adequate clinic facilities should be provided, including availability of free or inexpensive laboratory services.

The solution of the problem of treatment for the many neglected cases of syphilis is not in establishing more and larger clinics, but rather in coöperation with private practitioners and voluntary hospitals and clinics.

Departments of health may aid, however, by providing free drugs, free consultation regarding therapy, and the services of a public health nurse in the follow-up of lapsed cases.

Sources of funds for a city program are, first, the city budget; second, Security Act funds through state departments of health; and third, WPA funds through special projects.

Local voluntary agencies such as social hygiene societies can be of great practical assistance in many aspects of the program, especially with regard to popular education, professional training, and the creation of favorable public opinion.

Rabies Widely Prevalent Among Dogs: Cases Doubled in 1937.—More than two thousand rabid dogs have been reported in California during 1937, twice as many as have ever been reported during a single year in the history of the State. Most of these diseased animals have been discovered in Southern California, but recently more have been found in the central coast region and in the San Joaquin Valley. The Sacramento Valley is free of the disease, and only a few cases have been found in the region north of the bay of San Francisco.

At the request of local health officers the State has placed a quarantine on dogs and cats in Santa Clara and Ventura counties. Under the quarantine regulations all dogs and cats must be kept under confinement upon the private premises of the owners under restraint by leash or in closed cages or paddocks. It is the duty of peace officers and deputies of the county health officer to enforce the provisions of the order.

The great reservoir of rabies infection is in the stray dog population. If stray dogs were reduced to a minimum, rabies could be controlled easily. It would appear that the spread of the disease is from south to north, and it is probable that stray dogs are responsible for the spread. Communities in which stray dogs are impounded regularly and in routine manner have little to fear from rabies.

A veterinarian in Los Angeles County was recently bitten on the thumb by a dog that he had under treatment. It was not known until after the dog died that he suffered from rabies. In spite of the fact that the Pasteur treatment for the prevention of rabies was given to the patient, he developed the disease ten weeks after having been bitten and died. There is no history of any individual contracting rabies having recovered. The treatment is preventive only, and once the symptoms of the disease appear death is certain.

Children cannot be adequately protected against this highly fatal disease in those communities where no efforts are exerted to control stray dogs. When the disease is as prevalent as at the present time, it is important that community action be taken in the provision of adequate safeguards. The State Department of Public Health is ready to assist any community that may desire to take definite action in the control of the disease and in establishing preventive measures.

* Condensed from the article by Walter Clarke, M. D., Executive Director of The American Social Hygiene Association, in the March 6, 1937, *Journal of the American Medical Association.*

Botulism.—A fatal case of botulism was recorded in Los Angeles County, where a woman opened a jar of home-canned corn, tasted it without swallowing any, and threw the contents to the chickens. Ten chickens died the same day and five the next day, all having symptoms of limber neck. The woman was taken sick October 5, within thirty hours after tasting the corn, and died October 12.

Marriages Increase. — There were 48,305 marriages registered in California during the first nine months of the present year, as compared with 44,938 such events that were registered during the first nine months of 1936. This represents an increase of 7.5 per cent. The comparison of marriages by the months for the periods under discussion is as follows:

	1937	*1936*
January	4409	4201
February	4000	4058
March	4428	3959
April	4509	4516
May	4366	3870
June	8081	7263
July	6001	5733
August	6155	5406
September	6336	5932
Total	48,305	44,938

Lemon Juice.—Nearly half the samples of so-called pure lemon juice taken by food and drug inspectors and sent to the State Laboratory for analysis have been found to be adulterated with citric acid and water so as to cheapen the product.

Most of such lemon juice is sold to "on sale" places in unsealed bottles, making it sometimes difficult for the inspectors to ascertain whether the manufacturer or retailer is responsible for the adulteration.

One retailer and one manufacturer were cited for violation of the Pure Foods Act in that the product, labeled "100 per cent Pure Lemon Juice," contained one-half water and added citric acid.

The retailer claimed that he did not tamper with the bottle, and the manufacturer stated that it was made of pure lemon juice.

However, another sample of the manufacturer's product taken at a different place showed the identical analysis of that taken at the original retailer, which proved to our satisfaction that the manufacturer was responsible for the adulteration.

Ten Planks in a Platform.—The members of the Maternal Welfare Committee of the New York State Medical Society recently sat around a table in Rochester for their third annual meeting and drew up suggestions to help county medical societies in the state provide safe care for mothers.

The ten suggestions, as reported in the *State Journal of Medicine*, are as follows:

1. More emphasis should be placed on adequate rather than on minimum standards of prenatal care.
2. Greater attention should be given to eugenics rather than to birth control.
3. Every county medical society should include in its postgraduate instruction for doctors "refresher" courses in obstetrics.
4. The study of maternal deaths should be continued to determine preventability, with a committee meeting regularly.
5. A physicians' speakers' service should be organized for lay groups.
6. In each county of the state, a large public meeting should be held to bring to the attention of everyone the need for saving the lives of mothers and babies.
7. Greater emphasis should be placed on the value of a routine Wassermann test for syphilis for every prospective mother immediately after a diagnosis for pregnancy is made.
8. The coöperation of all interested agencies in the community should be enlisted.
9. The interest of women should be secured, particularly such groups as the Woman's Auxiliary of the County Medical Society.
10. The assistance of the Maternity Center Association should be sought.

National Tuberculosis Association. — Dr. Cameron St. C. Guild of the National Tuberculosis Association will be one of the visiting lecturers on public health at the University of California from January 16 to February 19. Doctor Guild, who is secretary of the Committee on Tuberculosis Among Negroes of the National Tuberculosis Association, will lecture on rural health administration.

Federal Grants Totaling $16,318,640 for Public Assistance in Eighteen States Announced.—The amount of the grant for each form of assistance, the total federal funds allotted and the estimated number of individuals being aided under the various California programs during January, are shown in the following table:

State	Aid to	Estimated Number of Recipients	Grant	Total Federal Funds Allotted to State
California	Aged	95,000	$4,894,975.55	$5,540,429.83
	Blind	5,300	261,088.98	
	Children	28,000	384,365.30	

Association of Western Hospitals' Twelfth Annual Convention.—A gathering of equal moment to medical men and hospital authorities alike will take place in San Francisco at the Fairmont Hotel on February 28 and March 1, 2, and 3. It will be the twelfth annual convention of the Association of Western Hospitals and the western conference of the Catholic Hospital Association, meeting jointlty. At least two thousand delegates are expected from all of the eleven western states.

Of prime interest to medical men will be the appearance of Dr. Malcolm T. MacEachern, head of the hospital section of the American College of Surgeons; Dr. J. C. Geiger, Health Officer of San Francisco; and other leaders of national, state, and county medical associations.

The outstanding theme of the conventions will be hospital costs, which certainly concern the doctor as closely as they do the hospital. Group hospitalization, the establishment of colonies for both alcoholics and epileptics, a cancer clinic, and the problems of hospital personnel, will be other outstanding topics.

Medical men generally are cordially and earnestly invited to attend the sessions of the convention, and particularly the showing of the exhibits of hospital appliances which this year promise to be greater than ever before.

This is the annual meeting of some 1,500 hospitals in the West to discuss their common problems and their common needs.

Faith in Radiation May Hinder Cancer Treatment.—Despite the great strides that have been made in treating cancer with irradiation, early diagnosis and prompt surgery are still the most effective weapons which medical science can employ in combating this disease.

This view was expressed recently by Dr. Frank Hinman, clinical professor of urology at the University of California Medical School, in pointing out that faith in the success of radium and x-ray treatment has led to many failures in the treatment of cancer and caused some physicians to lose sight of the value of early treatment and surgery.

Doctor Hinman pointed out that irradiation has replaced surgery in the treatment of certain forms of cancer. In these cases early diagnosis, which means recognizing the cancer before it has time to spread throughout the body, while extremely important, is not as essential as when surgery is required.

Nevertheless, with the exception of a few radio-curable cancers, mortality from this disease remains about as high as ever. Doctor Hinman attributes this to the fact that success with irradiation has lowered efficiency in dealing with radio-resistant forms of cancer. Early diagnosis is made no more frequently and acted upon less promptly than in the days before irradiation seized the medical fancy. These two factors, believes Doctor Hinman, explain many failures in cancer treatment.

Until the cause for cancer is determined and a specific cure found, he says, physicians should stick to the slogan, "Early diagnosis and prompt surgery." — *University of California Bulletin,* January 4, 1938.

Know the Truth—Save Our Youth.—The American Social Hygiene Association, of which Dr. William F. Snow, one time Director of the California State Board of Public Health, is now the executive officer, recently printed the following:

"Of the half-million new cases of syphilis which come to physicians and clinics for treatment each year, one in five is found among youngsters under twenty years of age.

"More amazing, perhaps, is the fact that half of all new syphilis infections are contracted by individuals between twenty and thirty years of age. Yet this age group represents only one-sixth of the total population.

"Dr. Ray Lyman Wilbur, President of the American Social Hygiene Association, said recently: 'The real perils in America today are alcohol and gasoline on the highway and the gonococcus and spirochete in the byway,' and, he added, 'syphilis and gonorrhea are certainly among the greatest menaces to boys and girls.'

"Young people are learning the truth about these diseases and are accepting the challenge to fight these foes of health and happiness. Parents, youth leaders, social hygiene agencies, and health authorities see the tremendous opportunities, backed by an awakened public opinion, for successfully attacking the enemy."

Severe Heart Pain Due to Obesity in Many Cases.—Severe and sometimes disabling chest pains which resemble the symptoms of angina pectoris may be traced in many instances to the patient's excessively overweight condition, according to Dr. William J. Kerr, professor of medicine in the University of California Medical School.

Speaking before the eighth annual postgraduate symposium on heart disease held in San Francisco recently, Doctor Kerr revealed that the University Medical School has obtained excellent results in treating overweight sufferers from chest pain, breathlessness and low blood pressure.

The pain, similar to that of angina pectoris in this condition, is presumed to be due to an insufficient supply of oxygen to the muscles of the heart. Doctor Kerr believes, on the basis of personal observation of a large number of patients, that the chief and precipitating causes of the pain lie outside the heart itself. He lays the blame on conditions which prevent the heart from filling with an adequate amount of oxygen carrying blood. Extreme obesity, and resultant abnormal posture is one of these conditions, he says.

At the University Medical School, overweight patients have been put on a special diet designed to reduce the weight to normal, and properly fitted abdominal belts have been applied. Later, postural exercises have been prescribed. In every case in which this has been done, the attacks of pain have been relieved.

The reason for this cessation of pain cannot be listed categorically, according to Doctor Kerr. However, he believes that it is due to the restoration of the normal position and movements of the diaphragm, the change in pressure within the abdomen and chest, and the increased freedom of motion enjoyed by the chest in breathing. All these factors apparently combine to aid the heart in filling itself with an adequate supply of blood.

Press Clippings.—Some news items from the lay press follow:

New Method Found in Disease War

Infantile Paralysis Progress Reported at Stanford

One more step has been taken by science in the effort to prevent infantile paralysis by applying zinc sulphate to the olfactory nerve.

Two Stanford University scientists, Dr. E. W. Schultz and Bacteriologist L. P. Gebhardt, continuing their researches, have developed a means to apply the zinc sulphate by a convenient technique, using droppers instead of the difficult spraying method heretofore employed.

Doctor Schultz warned the development represented progress and not achievement of a goal. Further tests will be carried on with funds raised, in part, through President Roosevelt's annual birthday ball, January 30.—*San Francisco Examiner,* January 13, 1938.

Snake Bite

We have always had a high regard for the California Medical Association, but we confess that our enthusiasm has somewhat cooled. With an utter disregard for one of our cherished traditions, it has announced publicly and flagrantly that for snake bite while on vacation one should take no alcoholic stimulants whatever. We may as well have no snakes, no vacations, or nothin'. — *Clearwater Journal* (Hynes, California), December 9, 1937.

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Dramatizing Health

Borrowing a leaf from the Chinese, American public health officials are striving more and more to keep people from getting sick, rather than treating them after they do. Both the San Francisco and the New York World Fairs will illustrate this trend most graphically. The whole field of disease will be dramatized at the health show featuring the New York Exposition.

Fair leaders have recognized that health is the most important topic in the world. They will present in striking form mankind's war on cancer, tuberculosis, heart disease, and half a hundred other major scourges. Science's strides in battling these death-dealing forces will be shown. Methods of research and experiment will be explained.

Visitors will be able to learn for themselves many simple steps which they themselves, as laymen, can use in combating the menaces.

A human figure eighteen feet high, the heart beats of which can be heard all over the building, will feature one display. This transparent figure will be an object lesson in physiological perfection, to be used in conjunction with the other displays.

This idea of familiarizing the public with the fundamentals of health undoubtedly will spread. Dramatization of the problem will make the ultimate conquest of disease easier.—Editorial, *Los Angeles Times*, January, 10, 1938.

* * *

United States Medical Group Seeking Free Aid for Nation's Poor

Chicago, Jan. 12.—(INS)—Plans to provide adequate free medical service for the poor throughout the United States were announced tonight by the American Medical Association.

An editorial in the Journal of the American Medical Association said that "an attempt will be made to apply on a nation-wide scale the best features of the plans already in effect, utilizing in each county the fullest extent of the services there available."

The new program is to provide under the leadership of the county or other medical societies a medical service "for the indigent and those partially able to pay."

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Collection Bureau: Orange County, California

(From Medical Economics, January, 1938)

To the Editors of Medical Economics:—An article published by Medical Economics [January issue, 1935, page 18] about a coöperative collection agency established by doctors in New Orleans caught the attention of a group of doctors here in Orange County, Cal.

In April, 1935, a committee appointed by the local medical association, organized and incorporated the Orange County Medical Bureau.. Each doctor who signed as a member was assessed $10. I was put in as manager with one girl as assistant. We opened an office, and the doctors sent in about 1,500 accounts as a starter. By May 15 we were off.

Four months later we had lifted ourselves out of the red. We have gone ahead consistently ever since. Our equipment is entirely paid for; we have no debts; our employees have increased from two to five; and everything looks promising for the future.

Thought you'd like to know.

Robert Speed, Manager
Orange County (Cal.)
Medical Bureau.

* * *

Harkness Makes $8,000,000 Gift

His Two Donations Go to Commonwealth Fund

Edward S. Harkness has made two gifts totaling $8,000,000 to the Commonwealth Fund, of which he is president, it is revealed in the 1937 report of the organization.

Although the donations were made primarily for general philanthropic purposes, temporarily the income from $3,000,000 will go toward the development of rural hospitals, and from the remaining $5,000,000 for medical research and education.

During the year ended in September, grants of about $1,800,000 were made from the current income, the report revealed.

The chief uses of this outlay were for the provision of country community hospitals, the encouragement of public health services in rural districts, the improvement of medical teaching, research, and professional education.

In all, 74 per cent of the fund's total appropriations for last year went for such projects.

The two latest donations of Mr. Harkness now bring the endowment of the fund, which was set up by Mrs. Stephen V. Harkness, to more than $50,000,000.—*New York Sun*, January 8, 1938.

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Politicians on the Spot

Warners are at work upon another picture that will expose the nefarious doings of politicians. The new one will be called "County Hospital," and will show how the politicians bring about deplorable conditions in the public institution. No cast has been chosen, as the story is only now in the first stages of preparation, but a big star cast is planned for the picture. The story is one inspired by recent local headlines. — *Hollywood Citizen-News*, December 23, 1937.

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Nation-Wide Paralysis Group Forms

Drive for Founders of New United States Foundation Will Open January 17; Members, Funds Sought

New York, Jan. 9. — (INS) — Marking America's first nation-wide fight against the "maiming death," a drive for founders of the new National Foundation for Infantile Paralysis will be launched January 17, it was disclosed tonight.

The drive will augment the thousands of celebrations Saturday, January 29, in honor of the President's birthday, Chairman Keith Morgan of the Executive Committee announced.

Those who join the new permanent organization will be enrolled as "founders." Morgan said. Certificates will cost $1 each. The enrollment will continue from January 17 through Saturday, January 29.

President Roosevelt will be founder No. 1. While no goal has been set, the committee hopes to enroll at least two million.—*Los Angeles Examiner*, January 10, 1938.

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Plan New University of Southern California Medical School

Alumni Asked to Aid Drive at Meet

Construction by the University of Southern California of a new modern medical school near the General Hospital. That is the aim today of Dr. Paul McKibben, dean of the medical school, and faculty members. The project has the support of Dr. R. B. von KleinSmid, president of the university.

Disclosure of the plan, as yet only in the stage of discussion, was made by Doctor McKibben at the annual dinner of the Medical Alumni Association of the University of Southern California in the Los Angeles County Medical Association.

Must Have New School

"We should have such a new building in keeping with the high standing of the medical school of the university." Doctor McKibben said. "And we want the alumni to help in realizing this dream."

A few minutes later Doctor von KleinSmid, in addressing the alumni on international conditions, prefaced his talk with the declaration:

"We must have a new medical building. We will have it."

Dean McKibben cited as an instance of the high standing of the scholarship of the medical school the fact that in recent years not a single graduate has failed in examinations before the State Board of Medical Examiners.

"We need the help of the alumni in our building program and to keep the school where it is—at the top," he added.

The banquet was one of the best attended in years. Dr. H. B. Tebbetts, president of the alumni, presided. In addition to Dean McKibben and Doctor von KleinSmid, addresses were made by Dr. Frank F. Barham, publisher of The Evening Herald and Express, an alumnus, class '05, and Dr. George Kress, president of the Los Angeles County Medical Association, who had long been associated with the medical school.

A reverent silence pervaded the room when Doctor Kress asked that a toast be drunk in honor of the founder of the school, Dr. Joseph Pomeroy Widney, physician, author, soldier, scholar, and statesman, who will celebrate his ninety-sixth birthday December 26.

"This grand old man is now blind, but his mind is still alive with the fire of his youth. He is still dictating books. Only last year his latest was published—not for profit, but for the benefit of mankind. Let us drink a toast in his honor."

Then Doctor Kress read the minutes of the first meeting of physicians who had gathered to organize the medical school way back in the early eighties. Included in the list were men who had become famous in the medical annals of California and also of the nation. Doctor Kress recounted that the first class to graduate numbered eight.

Doctor von KleinSmid spoke also on foreign affairs.

"We as a nation are the strongest in the world," Doctor von KleinSmid said. "We have 50 per cent of the currency wealth in the world. We are almost self-sufficient. We are no longer isolated, no matter how much we may wish to be."

For Anglo Alliance

An alliance between the United States and the English-speaking world is the hope for the preservation of democratic civilization, he asserted.

Election of officers of the Medical Alumni Association was a part of the evening's program. Dr. Harold R. Witherbee was elected president; Dr. Pierre Viole, vice-president; Dr. Anton Laubersheimer, secretary; and Dr. Alonzo Y. Olsen, treasurer.—*Los Angeles Herald-Express.*

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Southern California Joins War on Infantile Paralysis

Southern California today was lined up to do its share in a nation-wide drive to raise $12,000,000 to fight infantile paralysis in 1938, following a luncheon yesterday of civic leaders, public officials, motion-picture executives and representatives of the clergy, at which hearty support was pledged to the movement.

Instead of confining the fund-raising to a general ball on January 29, birthday of President Roosevelt, as has been done in the past, efforts will be made to obtain small amounts from everyone interested in the humanitarian work, it was explained by Louis B. Mayer, principal speaker.

Each place where public dancing is conducted will be asked to donate 25 per cent of its receipts on the night of the 29th, emphasizing the slogan, "Dance with the President." A "parade of dimes" also will be sought from individual contributors.

"By these means we expect to increase the operating funds of the Warm Springs Foundation, now known as the National Infantile Foundation, from $1,000,000 to $12,000,000 annually," Mayer said.

A telegram was read from Joseph M. Schenck, regional chairman of the foundation, declaring that the nation looks to Southern California to point the way in the drive.

George Jessel, radio and screen comedian, was toastmaster. Others taking part or at the guest table included the following:

Dr. Harlan Shoemaker, Los Angeles, chairman of the drive; Justus Craemer, State Building and Loan Commissioner, who, representing Governor Merriam, declared the week of January 24 had been proclaimed "National Infantile Paralysis Week" for California; Monsignor Thomas O'Dwyer, representing Archbishop John J. Cantwell; Rabbi Edgar F. Magnin; Episcopal Bishop W. Bertrand Stevens, J. M. Ruben, Metro-Goldwyn-Mayer vice-president; Sheriff Eugene Biscailuz; Roy Becker, President of the Board of Education, who spoke for the full complement of board members present; Vierling Kersey, Superintendent of City Schools; County Supervisor Roger Jessup; City Health Officer Dr. George Parrish; Chief of Police James E. Davis; Walter J. Braunschweiger, Chamber of Commerce past president; and numerous campaign chairmen for Southern California counties.—*Los Angeles Herald-Express,* January 5, 1938.

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Doctor Explains How He Restored Victim's Memory*

Miracle Man?

Dr. ———, Redwood City chiropractor, aided in restoring the memory of a man who says he is James Saunders of Ohio.

Although Dr. ———, Redwood City chiropractor, whose remarkable achievement in restoring the memory of Jimmy Saunders, amnesia victim, today, would deny he is a "miracle man," observers who watched the amazing results of the doctor's work held otherwise.

To Dr. ——— the task was simple. Each year, he said, he returns for summer work at the Palmer School of Chiropractry in Davenport, Iowa, where he keeps up on the latest developments in his profession.

He explained that all cases of loss of memory are due to spinal displacements which cause vertebrae to press upon the spinal cord.

In Saunders' case, Dr. ——— declared, the atlas bone, uppermost vertebra in the spinal column, was out of joint slightly forward and to the left.

This he detected by use of a newly developed instrument known as the "neurocalometer," which consists of a calibrated dial and an indicating needle. Pressed against the back along the spinal column, this instrument locates "hot spots," where nerves have been placed under a strain, the doctor stated.

X-rays taken also indicated the maladjustment.

To correct the trouble and bring back Saunders' memory, Dr. ——— merely "tapped" the misplaced bone back into its correct location, releasing the pressure on the spinal cord.

Such a maladjustment as that from which Saunders suffered may have been caused by an accident, jar, or even a strain, the doctor said.—*Redwood City Press.*

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Pasadena Stray Dogs Face Death by Bullet*

Pasadena officials today put into effect a drastic dog-regulation ordinance which:

Gave police officers authority to shoot on sight any stray dog.

Forbade people walking their pets on the street even on leashes.

Permitted dogs to ride only in closed automobiles.

And fixed a penalty of $500 fine or six months in jail for any owner violating these mandates.

The ordinance was passed by the Board of City Directors after a stormy meeting as an anti-rabies measure.

Charges that "the rabies scare began with the reappointment of a city health officer in Los Angeles under whose former administration rabies scares were common" were contained in a letter of protest from Harold Weight of 110 North Mentor Avenue.—*Los Angeles Herald-Express.*

* * *

Daylight Ban Set on Dogs

But Pasadena Council Will Permit Owners to "Walk 'Em" at Night

Pasadena, Jan. 18.—Pasadenans may "walk their dogs" by moonlight or starlight, but it will continue to be illegal to exercise them by sunlight, the Board of City Directors decreed today.

Following a stormy and frequently amusing public meeting in the City Hall, the Directors unanimously gave first reading to an amended emergency rabies quarantine license. Effective tomorrow, the much-amended ordinance now gives dog owners the right to exercise their pets on leash between 7 p. m. and 7 a. m.

Beware of Crowds

But leashes must not be more than five feet in length, the dogs must not approach a crowd or come closer than five feet to any public buildings, especially markets, and must be kept out of all city parks.

The session was enlivened when G. L. Kelley of East Pasadena suggested that now that the Colorado Street bridge has been fenced on both sides to prevent suicides of humans, it would be a good idea to fence it at both ends for the benefit of dogs. It would solve the whole problem, he declared, if the bridge were completely enclosed to house this city's 5,000 canines.

"Seeing Eye" Problem

Although city officials previously decided to "wink" at possible infractions of the ordinance by owners of "seeing eye" dogs, the question again was raised by C. L. Lilley, spokesman for a dog owners' committee.

The prize letter read at the meeting was from Mrs. M. M. Hammond of Monrovia. "I certainly wouldn't like a member of the Pasadena board to bite my dog," read the letter in part.

Hilarious Side

That there is a serious as well as hilarious side to the rabies quarantine was disclosed by the report that Dr. Roger W. Barnes of 4804 Hillard Avenue, La Canada, has been forced to take a double Pasteur treatment after being bitten by a rabid chow dog last Sunday. At the time of the attack the Los Angeles physician assertedly was walk-

* This Redwood City press item was transmitted as an enclosure to the letter which follows:

Redwood City, California.

To the Editor of California and Western Medicine:—"Can any good thing come out of Nazareth?" Lest you may not have had the full account of the advances in scientific medicine as developed in our town of Redwood, I am enclosing a clipping from the local paper.

To have completed the cure, the cultists might well have manipulated the victim's "crazy bone"—but, possibly, he was not as crazy as appeared and, having had recognition or finding that his present condition was not better than when he left his home (he was in the county jail), he may have decided that he could venture back to sanity.

Yours truly,

———

* Editor's Note.—This series of items regarding rabies is printed to show the trend of lay opinion.

ing with his own great Dane and his small terrier. The chow, which later killed four other dogs, picked up Doctor Barnes's terrier and raced away with it.

The rabies situation as it affects Los Angeles County was clarified today by Dr. Wilton Halverson, city health officer. He explained that although he feels the problem ultimately must be solved by vaccination of every dog, there is a present necessity for rigid quarantine.—*Los Angeles Times*, January 19, 1938.

* * *

Pasadena Frees Dogs Twenty-Four Hours Daily

Pasadena dog owners, crowding into the chambers of the City Directors to protest the drastic anti-rabies ordinance which made their pets virtual prisoners, won a concession today when the directors amended the ordinance to allow dogs to be out twenty-four hours a day, provided they are kept on leashes not more than five feet in length.

The ordinance as first passed forbade dogs to be out at any time under any circumstances. The measure brought a storm of protest, and an amendment allowing the dogs out on leash between 7 p. m. and 7 a. m. was passed.

The protest continued until today's amendment was passed. It will be adopted formally by the board in its second reading Tuesday.

The amendment was passed after Attorney Rollin McNitt and Carleton Lilley, representing dog owners, spoke from the floor, advocating it. Upon its adoption the board asked all the forty spectators who were "satisfied" to rise, and attendants reported every man and woman stood up.

The amendment prohibits the dogs from being taken within five feet "of any public building, store, place of amusement or park where people congregate."

A mass meeting will be held in Altadena tomorrow evening, January 21, at 8 o'clock, in Elliott Junior High School on Lake Street, for the purpose of protesting the drastic dog ordinance in effect at Altadena, which is even more drastic than that in Pasadena. The meeting is being called by citizens of Altadena. Frank Foster Davis of Altadena is chairman of the committee for the mass meeting. Distinguished speakers will be present.—*Los Angeles Herald-Express*, January 20, 1938.

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Pasadena Acts to End Rabies Scare

Pasadena, Jan. 20.—Alarmed at the prospective loss of Eastern winter tourists, Pasadena's Board of City Directors acted quickly yesterday to minimize the city's rabies scare.

Board members cast a first vote on an emergency amendment to the city's drastic dog-control ordinance, and if the amendment is adopted on second reading next Tuesday, Pasadena canines once more will be permitted on the streets if held on leashes.

Just as quickly, Pasadena health department officials thumbed through old records to show that the present wave of rabies is not serious after all. They pointed out that while the city scored thirty-five cases of proved rabies in 1937, as compared with thirteen cases each in 1935 and 1936, there have been far more severe "epidemics"—such as in 1931, with thirty-nine proved cases, and in 1928, with forty-one cases.

The present ordinance, which placed all Pasadena dogs under "shotgun quarantine"—to be shot dead if sighted on any street—brought a shout of protest from dog lovers, who declared that the quarantine would work such a hardship upon both pets and their owners that many dogs would have to be exterminated.

Frank Foster Davis of Altadena announced that he would hold a mass meeting in Elliott School Auditorium tonight to propose the drafting of a dog-on-leash quarantine similar to the Pasadena amendment.—*Los Angeles Examiner*, January 21, 1938.

* * *

California Social Welfare Department

Mrs. Splivalo Witness in Personnel Hearing

Dismissal of several employees of the State Social Welfare Department was urged by Governor Frank Merriam, according to testimony before the State Personnel Board during the hearing on the petition of Miss Kathleen McLaren, former employee of the department, who seeks reinstatement and payment of $200 a month back salary since December, 1934.

Called as a witness on behalf of Miss McLaren, Rheba Crawford Splivalo, Los Angeles Evangelist and former director of the State Social Welfare Department, said that, following Governor Merriam's election, her resignation was asked, that she resigned on December 13, 1934, that Mrs. Florence Turner was named as her successor the next day and that Miss McLaren and several other employees of the department were removed.

The Evangelist commended Miss McLaren as a capable and efficient worker, who had served the Welfare Department for three years and previously had been in the finance department.

Mrs. Florence Turner, also testifying, told the board that the governor had told her to clean out the department and that on January 18, 1935, she accompanied members of the Social Welfare Board to the governor and he again told them to fire several persons.

This afternoon the board took up recommendations of its executive officer for a general revision of the state civil service classification which would involve an additional expenditure of $760,000 annually in salaries to state employees. Half of this amount would go to employees now receiving less than $100 a month, Fred B. Wood, chairman of the board, stated.—*Los Angeles Examiner*, January 21, 1938.

* * *

Sinclair Lewis Here; Assails Propaganda

Lively as a cricket, a tall scholarly man with red hair skipped from subject to subject in conversation like a water bug across the surface of a pond.

It was novelist and Nobel prize winner Sinclair Lewis talking at the Biltmore Hotel after his arrival here from Chicago by Santa Fe train to lecture on "Propaganda and Poppycock" tomorrow night at the Shrine Auditorium.

"Everything but science, religion, and sex are standardized in America," said Lewis as he crossed his elegantly silk-sheathed ankles.

"This is the result of the mass thinking that is spread to millions through the radio, movies, and press.

"All that would be necessary for a dictator to end democracy would be to control the media that already are ending individuality in America.

"Since we are all coming to think and talk alike, all that is necessary is to get us to thinking a dictator would be a good idea." . . .

Skipping back to propaganda, Lewis said:

"These propaganda forces are standardizing American thought and may make the nation susceptible to anti-democratic forces, singularly enough, by using the very scientific marvels that pioneer American individuality and initiative produced. . . .

"The syndicated writers are among the most effective propagandists, for they influence millions of readers, and for that reason the quality of their writings ought to be increased tremendously." . . .—*Los Angeles Herald-Express*, January 19, 1938.

LETTERS

Concerning Woman's Auxiliary to the California Medical Association.

WOMAN'S AUXILIARY
TO THE
CALIFORNIA MEDICAL ASSOCIATION

Oakland, California,
January 20, 1938.

To the Editor:—May I take this opportunity to thank you so very much for the splendid editorial appearing in the January issue of CALIFORNIA AND WESTERN MEDICINE pertaining to the Woman's Auxiliary and our publication, *The Courier*. Nothing so spurs our membership on toward fulfilling aims and purposes of organization as an encouraging message from our parent body—the California Medical Association. Your editorial will indeed do this and will be an inspiration to all of us.

It is our aim to be informed and ready to aid in every way the cause of organized medicine, and thus justify our existence and your confidence in us as an Auxiliary.

1137 Mandana Boulevard.

Very truly yours,
MRS. HOBART ROGERS, *President*.

Concerning January editorial: Woman's Auxiliary to the California Medical Association.

WOMAN'S AUXILIARY
TO THE
CALIFORNIA MEDICAL ASSOCIATION

San Francisco,
January 22, 1938.

To the Editor:—May I take a moment of your time to tell you how very much I appreciate the very splendid

editorial that appeared in the January issue of California and Western Medicine regarding the Woman's Auxiliary to the California Medical Association. Your article will, I believe, bring about the desire and aim of those interested in that organization—a membership that will include every doctor's wife!

You mention a supplement to California and Western Medicine. In letters exchanged between the National Chairman of Publicity and myself, we have discussed at length that very point. Now that you have mentioned it and approved of it, something will probably be done. The Auxiliary will be grateful for the deep interest you have shown.

3880 Clay Street.

Very sincerely yours,
Mrs. Fred H. Zumwalt.

Concerning article on Medical Care in San Francisco.

To the Editor:—With reference to the story that appeared in the San Francisco *News* as to the so-called "Dodd Report of a Survey on Lack of Medical Care," may I state that the source of this interview and the reason therefor are as follows:

I was called on the telephone early in the morning by a special writer of the San Francisco *News* with reference to certain statements in which Doctor Dodd was quoted. I vehemently denied the lack of medical care in San Francisco as quoted by him. Likewise, I charged Doctor Dodd with a lack of any great amount of knowledge as to medical practice or medical problems here. I stated most sincerely (which, however, was not used) that the statements as to lack of public health training by the members of the State Board of Health were entirely incorrect, as these members knew more public health than many men who supposedly were trained in public health and consequently they did not need the training. . . .

Director of Public Health,
City and County of San Francisco.

Sincerely,
J. C. Geiger, M.D., *Director.*

Concerning the sixty-eighth annual meeting of the California State Dental Association, Stockton.

To the Editor:—We would like the members of the California Medical Association to know that the California State Dental Association is holding its annual meeting at Stockton, California, on April 4, 5, and 6, 1938.

We are having as guest speakers, C. Augustus de Vere of New York City; Thomas Mullen, M.D., Albert Davis, M.D., D.D.S., J. B. S. Saunders, M.D., all of San Francisco; and Hermann Becks M.D., D.D.S., University of California.

These clinicians, as well as work being done in public health matters, should be of interest. Admission by presentation of membership card of the California Medical Association.

1003 Medico-Dental Building,
Stockton.

Very truly yours
C. E. Stabler, D.D.S.,
General Chairman, California State Dental Convention.

Concerning donation to Lane Medical Library.

Stanford University School of Medicine
San Francisco, California,
December 22, 1937.

To the Secretary:—Thank you indeed for your letter of December 20 and the enclosed check for $119, which is the balance of the 1937 contribution from the California Medical Association to the Lane Medical Library. I have turned this check over to President Wilbur of Stanford University.

Once again I am pleased to acknowledge the receipt of such contributions and express our thanks and gratitude to the California Medical Association for this continued support. I hope you know how much good is done to members of the medical profession, not only in the Bay region but all over the State, by this support. It is wonderful and really rounds out our program and permits us to do a great deal of reference work and send books to doctors that otherwise we would be unable to do.

Very truly yours,
L. R. Chandler, M.D., *Dean.*

Concerning the American Physicians' Art Association Exhibition in San Francisco.

San Francisco,
January 2, 1938.

To the Editor:—Will you kindly run the following announcement in your valued journal so that doctor-artists may be made cognizant of this exhibition.

Respectfully yours,
F. H. Redewill, M.D.

Announcement

The American Physicians' Art Association, a national organization of medical men who have ability in the fine arts, will hold a first national exhibition in the San Francisco Museum of Art, San Francisco, California, in June, 1938. (The American Medical Association convention is June 13-17 in the same city.) The American Physicians' Art Association already has an outstanding membership. There are three classifications for membership: active, associate, and contributing. The first annual exhibition promises to be of unusual interest, with entries to be accepted (after jury selection) in the following classifications: oils, watercolors, sculpture, photography, pastels, etchings, crayon and pen and ink drawings (including cartoons), wood carvings, and book bindings. Scientific medical art work will not be accepted. The exhibition is not limited to first showings. All entries close April 1, 1938. Any physician interested should communicate at once with the Secretary of the American Physicians' Art Association, Suite 521-536 Flood Building, San Francisco.

Concerning Christmas Seal articles: Letter of Appreciation.

December 29, 1937.

To the Editor:—Thank you so much for sending us the copy of your magazine with its notice of our 1937 Christmas Seal sale. This contribution will be a great help to our campaign and we appreciate your splendid coöperation.

50 West Fiftieth Street,
New York City.

Cordially yours,
Elizabeth Cole,
Assistant Publicity Director.

Concerning the third annual Postgraduate Course, Portland, Oregon.

To the Editor:—We would like to call your attention to the third annual Postgraduate Course in Ophthalmology and Oto-Laryngology, which will be held in Portland, Oregon, April 3 to 9, 1938. This course is sponsored jointly by the Oregon Academy of Ophthalmology and Oto-Laryngology and the University of Oregon Medical School. The course is primarily intended for those in special practice.

Our guest teachers this year are Dr. A. C. Furstenberg and Dr. Sanford Gifford. The mornings will be dedicated to programmed papers by our guests. There will be a round-table luncheon each noon hour, with question box. The afternoon sessions will be held at the out-patient clinic of the Medical School, and in the evenings Dr. Olof Larsell, professor of anatomy at the school, will demonstrate the surgical anatomy of the head and neck. There are several other features in the formative stage which will be announced later in the preliminary program. Copies of this program may be secured by writing Dr. Paul Bailey, 929 Medical-Dental Building, Portland, Oregon.

Sincerely yours,
Paul Bailey, *Secretary.*

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

May a Physician Refuse to Give Expert Testimony Unless First Paid a Reasonable Compensation?

The Supreme Court of Kansas in a recent decision, *Swope* vs. *State*, 67 Pac. (2d) 416, has answered the above question in the negative. In that case a physician specializing in radiology, who had taken roentgenograms of the plaintiff's injured arm at the request of the defendant, Safeway Cab Transport and Storage Company, refused to testify on behalf of the plaintiff or to produce his roentgenograms unless paid the customary expert witness fee of $25. The Court directed him to take the witness-stand and he was asked to produce the roentgenograms. He refused, and likewise refused to testify unless first paid his fee. The Court thereupon found him guilty of contempt, fined him and ordered him committed to jail until the fine was paid. The physician then applied for a writ of habeas corpus, and when his application for the writ was denied he appealed to the Kansas Supreme Court. The Court's opinion is summarized as follows in the *Journal of the American Medical Association*, issue of December 25, 1937, at page 2166:

The question, said the Supreme Court, whether an expert witness may be compelled to testify if special compensation has not been paid him, has been considered in many cases. In some of the states there are statutory provisions which permit the trial court to fix such compensation. There is no such statute in Kansas. The general rule as to compelling an expert witness to testify is stated in 70 C. J. 75, as follows:

"The more general rule is that, apart from statute, an expert witness may be compelled to testify as to matters of a professional opinion, or matters to which he has gained a special knowledge by reason of his professional training or experience, without any compensation other than the fee of an ordinary witness, and his refusal to testify unless paid an extra compensation may be punished as contempt."

The present case, the court said, does not present a situation where the witness, at the suggestion of the party calling him, did anything by way of preparation to testify, neither does it present any situation where there was any attempt to compel him by any order of court to prepare himself to testify. The professional services of the witness were rendered at the request and cost of a person other than the one calling him to testify. It was contended that Doctor Swope refused to produce the roentgenograms which the subpoena had compelled him to bring because he anticipated that he would be asked to express his professional opinion based on them. Assuming that to be true, the court said, Doctor Swope was not warranted in refusing to produce the roentgenograms, nor would he have been warranted in refusing to answer questions based thereon.

There are experts of many kinds, professional as well as lay. Many men are experts in certain lines of endeavor. If physicians, dentists, lawyers, and engineers may refuse to testify concerning matters on which they may have opinions due to their respective trainings, simply because special fees have not been paid them, then a person qualifying as an expert shoe repairer may not be compelled to state what was the matter with shoes he repaired unless a special fee is paid him. It can readily be seen, the court said, that such a situation would be intolerable. It would tend to permit those who could afford it to produce witnesses whose testimony might be said to be expert and would prevent those without requisite means of the benefit of such testimony. We are not referring, the court said, to that class of cases where special preparation is required as a condition precedent to testifying, but to those where the witness is interrogated as to facts and opinions which he knows and has without such special preparation. In the absence of a statute authorizing the trial court to fix expert witness fees, or permitting the witness to refuse to testify until a stipulated fee has been paid, the court was not disposed to hold that a witness claiming to be an expert called on to give expert testimony may refuse to testify unless his demands have been met.

The court concluded, therefore, that the witness was not justified in his refusal to produce the roentgenograms and to testify, and the judgment of the trial court denying the application for a writ of habeas corpus was affirmed.

On one point, viz., the matter of forcing a radiologist to produce his roentgenograms in court by means of a subpoena, the Kansas decision is contrary to the Michigan case reviewed in California and Western Medicine, December, 1937, at page 432. The Michigan court held that the radiologist *owned* the x-ray negatives and, therefore, could *not* be forced to surrender possession of them. The Michigan decision represents the sounder logic and should have been followed in Kansas.

The decision of the Supreme Court of Kansas once again focuses attention upon the importance of securing legislation in California under which physicians would be protected in situations of the kind confronting the Kansas physician who refused to testify. The writer has long recognized the need for legislation along this line and, at the risk of repetition, quotes from his report on the State legislative session of 1937 addressed to the Council of the California Medical Association:

Bill Relating to Compensation for Expert Testimony (S. B. 446)

For several years last past individual members of the Association have been forced to render opinion evidence on behalf of a litigant in a legal proceeding and have not been able to secure any compensation other than the ordinary $2 witness fee for their services. This situation has been made possible by the fact that there is neither a statute nor judicial decision in this state requiring that a party to an action at law desiring opinion evidence of an expert must pay a reasonable fee for such professional services. In a number of states, courts have held that if a physician gives opinion evidence on behalf of a litigant without being first paid therefor, he cannot thereafter maintain an action to recover a fee for his services. In order that this rule might not become law in California, we prepared, after receiving authorization of the Council, a bill to be introduced in the legislature providing, in effect, that physicians (1) could not be required to give opinion evidence without first receiving a reasonable compensation therefor, and (2) if a physician did give opinion evidence without first being compensated therefor, he could later maintain an action to recover a reasonable fee for his services. The bill as drafted applied to all experts, including engineers, attorneys, dentists, criminologists, and many others, as well as physicians.

The bill was introduced by Senator McGovern as Senate Bill 446. It was not opposed in the legislature, and, due chiefly to the efforts of Senator McGovern and Doctor Harris, it was passed by both Houses, but through a misunderstanding it was not signed.

If a statute identical with or similar to Senate Bill 446, introduced by Senator McGovern at the 1937 session of the legislature, could be enacted, it would effectively prevent any possibility of the free use by litigants in civil cases of the personal knowledge of physicians and other experts.

† Editor's Note.—This department of California and Western Medicine, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

CLINICAL LABORATORY LAW IS CONSTITUTIONAL*

The Attorney-General was asked for an opinion relative to the constitutionality of the new Clinical Laboratory Act, Chapter 804, Statutes of 1937, which is, in effect, a revision of the Clinical Laboratory Law of 1935 which he declared unconstitutional. In his opinion, the Attorney-General states that the 1937 Act is constitutional. The opinion reads:

To reach this conclusion, a review of the Act is required. The chapter referred to went into effect on the twenty-seventh day of August, 1937, and is operative as to clinical laboratory technologists and technicians who are granted certificates without examination because of time spent in actively doing the work required by Sections 3 and 4 for the period prescribed for securing the respective licenses. The penal provisions of the Act, however, are not effective until January 1, 1938. Thereafter, according to Section 1, no person, firm, association or corporation may conduct, maintain or operate a clinical laboratory as defined in said Act unless such laboratory be under the immediate supervision and direction of a licensed clinical laboratory technologist or a person holding a valid and unrevoked phy-

* This opinion supersedes that presented in the article "Information Concerning New Laboratory Law," printed in California and Western Medicine, January, 1938, on page 67.

sician's and surgeon's certificate issued under the provisions of the State Medical Practice Act of this State; thereafter, according to the same section, no person may lawfully make any test or examination requiring the application of the fundamental sciences, such as bacteriology, biochemistry, serology or parasitology, unless said person possesses an unrevoked certificate issued by the State Board of Public Health as a qualified technician in the subject or subjects concerned with the test or examination, or possesses an unrevoked certificate as a clinical laboratory technologist, or is the holder of a valid and unrevoked physician's and surgeon's certificate, issued under the provisions of the State Medical Practice Act of this State.

Pursuant to the section above referred to, the State Board of Public Health has authority, by regulation, to provide for the exemption of one or more technicians in each laboratory, who shall be called apprentices.

Section 2 defines a clinical laboratory as follows:

"Any place, establishment, or institution organized and operated for the practical application of one or more of the fundamental sciences by the use of specialized apparatus, equipment, and methods for the purpose of obtaining scientific data which may be used as an aid to ascertain the presence, progress and source of disease."

Section 3 provides for the issuance of a certificate of licensure as clinical laboratory technologist to each person holding a degree in one or more of the fundamental sciences, issued by a *recognized* institution, who is found by the Board to be *properly qualified*, after written, oral or practical examination, conducted under such rules and regulations as the Board may from time to time promulgate. The section referred to does not define a recognized institution, and hence is so vague and uncertain that the portion thereof relating to the holding of a degree from a recognized institution is ineffectual for any purpose. The legislature has failed to prescribe what body must recognize the institution or upon what basis institutions should or should not be recognized. To read into the portion of said section referred to a requirement that such institution should be subject to recognition by the State Board of Public Health is not warranted by the context and would constitute at least quasi judicial legislation. On the other hand, principles of statutory construction do not permit an interpretation based upon a delegation of legislative authority unless the legislature prescribes that an administrative tribunal may adopt rules or regulations relating to technical, health or medical subjects, and leaves the enforcement thereof to technical or trained boards or persons. In no instance is there any reported case indicating that such delegation is proper where a method for measurement is not supplied in the legislation for the administrative officer or tribunal.

It is the view of this office, however, that the legislature did not intend that the entire Act fall because of its use of the ineffectual expression "recognized institution," but rather meant the Act to stand, provided persons could be found who were properly qualified to secure a certificate of licensure, after examination as clinical laboratory technologists. By eliminating the requirement for the holding of a degree in a recognized institution and permitting all applicants after the first day of January, 1938, to take examinations for certificate of licensure as clinical laboratory technologists, the Act practically in its entirety may be given effect. Elimination of the requirement as to the holding of a degree is permitted because of the legislative expression in Section 11 of said Act that should any portion of the Act be unconstitutional, it would have passed the remainder thereof irrespective of such unconstitutional features.

The latter part of Section 3 provides for the granting of licensure as clinical laboratory technologist without examination to those having the qualifications therein prescribed, who make application to the Board before January 1, 1938, and who pay the required fee. This so-called blanketing in of those persons practicing as clinical laboratory technologists is not subject to constitutional objection.

Section 4 is practically identical to Section 3, except that such section has no requirement concerning the length of time one must be engaged in technical work in a clinical laboratory before one might be permitted to take either written or practical examinations for certificate as technician.

Section 5 is the penal section of said Act, and prohibits, after January 1, 1938, persons not certificated as technologists or technicians to thereafter act as such. It likewise prohibits persons, firms, associations or corporations from employing technicians, except that they be certificated as provided for in said Act or are acting as apprentices as provided for in regulations to be adopted or enacted by the State Board of Public Health. This would indicate a legislative intention to leave to the State Board of Public Health the right to enact regulations not contrary to the provisions of the law itself. Such regulations must, therefore, because of the latter portion of Section 1 of said Act and the provisions of Section 5, prohibit apprentices from working or being employed in a clinical laboratory unless there are on the active laboratory staff one or more licensed clinical laboratory technicians. They may not authorize more than two apprentices to work or be employed at the same time in the same laboratory.

The last portion of Section 5 permits the State Board of Health to provide for the issuance of temporary certificates as technologists and technicians, to expire at such time as shall be sufficient to determine the qualifications of said persons for permanent certification, notwithstanding the other provisions of the Act.

Section 6 of the said Act provides as follows:

"None of the provisions of this Act shall apply to a clinical laboratory now operated or hereafter to be operated by nonprofit hospitals, by nonprofit hospital associations, or by any nonprofit hospital department which is chiefly maintained by dues or contributions from employees of a common employer or of a group of affiliated employers, the services of which are principally confined to such employees, their dependents and members of their families and persons disabled in or by reason of the operations of the employer or group of employers, or by the State of California or the United States of America, or any department, official or agency thereof, or to nonprofit foundations engaged in research work."

It is definitely the view of this office that all of the attempted exemptions in said section contained are unconstitutional with the exception of the exemptions as to clinical laboratories now operated or hereafter to be operated by the State of California, or by the United States of America, or any department, official or agency thereof.

We know of no sound reason which would warrant exempting clinical laboratories of nonprofit hospitals, nonprofit hospital associations, etc., from the operation of the Act, as the purpose of the Act is to protect the public from incompetent or inefficient technologists, technicians and apprentices, and such protection could not be secured by exempting nonprofit hospitals, nonprofit hospital associations, etc., from the provisions of the Act and permitting them to employ technologists, technicians, and apprentices having lesser qualifications.

On the other hand, it would appear that the legislature had the right to exempt the State of California and any department, official or agency thereof from the operation of the Act, for ordinarily qualifying acts do not apply to the State unless the State is specifically included therein. Indeed, in the situation under consideration, the legislature has gone further than is customary and has specifically excluded the State and its departments, officials, or agencies from the operative effect of the Act.

The exemption of the United States of America is likewise warranted in that the State of California has no authority to interfere with any federal agency acting within the scope of its federal authority. See *Ex parte Wilman*, 277 Fed. 819, and *Dobbins* vs. *Commissioner*, 16 Peters 435.

Although these cases relate to taxation, the principle therein expressed is applicable to the exemption.

This does not necessarily mean that if the attempted exemptions are eliminated from the Act that the entire Act is invalid. Indeed, it is settled law that if an attempted exemption is invalid and separable, the balance of the Act stands. Particularly is this the case where the Act itself indicates that the legislature would have adopted the statute with the invalid exemption omitted.

The rule is set forth in the case of *Bacon Service Corp.* vs. *Huss*, 199 Cal. 21, and at page 39 the Court said:

"Respondent relies on a statement in Lewis's Sutherland on Statutory Construction (Vol. 1, 2nd ed., Sec. 306), where it is said: 'If, by striking out a void exception, proviso or other restrictive clause, the remainder, by reason of its generality, will have a broader scope as to subject or territory, its operation is not in accord with the legislative intent, and the whole would be affected and made void by the invalidity of such part.' The foregoing is unquestionably the rule except when a contrary legislative intent is ascertainable from the language of the statute or the general purposes or terms of the Act. But when it appears in the statute that it was the intent that the separable void portion should not destroy the whole the invalidity of the entire statute will not necessarily result, especially when it is determined, as here, that such was the intent, and that the remainder is a full and complete legislative enactment of the subject to which it relates."

To the same general effect, see *State* vs. *Skinner* (Ala.), 101 So. 327.

Section 11 of the Act under consideration indicates a legislative intention to pass the Act should any section, subsection, subdivision, sentence, clause or phrase thereof be declared unconstitutional. This leaves in force the balance of the Act, save as to the recognized exempted official agencies, and makes every technologist, technician, nonprofit hospital association, etc., comply therewith.

Under Section 8, the State Board of Public Health is authorized to make rules and regulations providing for the reinstatement of technologists and technicians who fail to

pay the fees required by the Board within sixty days after the commencement of the year.

Such section likewise provides for a revocation of certificate "for good cause after hearing on notice."

The portion of said section providing for the reinstatement of the certificate is constitutional and proper. That portion, however, providing for the revocation of license for good cause is void. In *Hewitt* vs. *State Board of Medical Examiners,* 148 Cal. 590, the legislature undertook to permit the revocation of medical licensure by the Board of Medical Examiners in instances where the defendant made "grossly improper statements" in advertising a medical business. In discussing the language used in the statute, the Supreme Court of this State said:

"Taking a given advertisement by a physician, the members of one board might conclude that it contained 'grossly improper statements' while another board might reach an entirely opposite conclusion. One might conclude that the statement while 'improper' was not 'grossly' so. The advertisement of a physician which one board had determined did not come within the inhibition of the rule according to its judgment, a succeeding board might conclude it did. As the provision of the Act in question does not define what shall constitute 'grossly improper statements' but leaves it to be determined according to the opinions of the particular members of the board who happened to constitute it when the matter of revoking a physician's license therefor is before them, it is obvious, if such a provision can be sustained that it could operate disastrously not only upon individual physicians, but upon physicians of a particular school."

The case in effect holds that a license may not be revoked where the grounds of revocation are left to the whim or caprice of an examining board without any standard for their guidance. The language in said case is applicable to the proviso of revocation in this Act "for good cause." What might constitute "good cause" as to one board, might not constitute "good cause" as to another.

But this does not mean that the Act is unconstitutional because a license issued pursuant thereto may not be revoked or suspended pursuant to the Act in its present form. What has been stated hereinbefore with reference to *Bacon Service Corporation* vs. *Huss,* is applicable to the revocation language of the Act. The Act is, therefore, constitutional, but a license issued pursuant thereto may not be revoked. The advisability of an amendment to provide specific grounds for revocation is respectfully left to your discretion.

In conclusion, I particularly call to your attention the language of Section 10 of Chapter 804, which prohibits corporations and persons not possessing valid and unrevoked physician's and surgeon's certificates from practicing medicine and surgery or from furnishing the service of physicians for the practice of medicine and surgery. This language indicates a specific legislative intent to prevent persons licensed as technologists or technicians from making diagnoses. Persons so licensed may make findings as to particular bacteria, germs or chemical substances present in given specimens or samples, but may not, under the law, state that the presence thereof constitutes the presence or absence of any particular malady or disease.

Very truly yours,

U. S. WEBB, *Attorney-General.*

By Lionel Browne.

EDUCATOR DECRIES UNITED STATES SUBSIDY FOR MEDICAL PRACTICE

[*Criticism of the Plan of the "Committee of Four Hundred and Thirty"*]

Declaring their proposals would lead to socialization of medical practice and bureaucratic control of education and research, Dr. Robert Wilson, dean of the Medical College of the State of South Carolina, has issued a statement decrying recommendations of a group of physicians who have rebelled against the American Medical Association's opposition to federal subsidy and direction of their profession.

Doctor Wilson denounces the plan of the 430 medical men—a small minority of the 165,000 in the United States—as constituting "a serious danger to principles which the medical profession as a whole has regarded, and still regards, as fundamental." He envisions the proposals regarding the support out of public funds of medical education and medical research as "fraught with possible danger" and sees no safeguard in the principles as expressed against socialization of the profession and bureaucratic control.

"That each state should support medical education and, through its medical schools, should encourage and support scientific research," reads Doctor Wilson's statement, "is a thoroughly sound policy, but the control of such activities by the Federal Government should be viewed with the gravest apprehension."

"That it is the purpose to bring under federal control all of these (medical, educational, hospital, and laboratory) activities," continues Dean Wilson's statement, "seems obvious from Proposal 9, in which it is suggested 'that the adequate administration and supervision of the health functions of the Government, as implied in the above proposals, necessitates, in our opinion, a functional consolidation of all federal health and medical activities, preferably under a separate department.'

"This provision means nothing else than bureaucratic control both of medical practice and of such education and scientific research, which can attain the highest degree of usefulness only when permitted complete freedom of operation untrammeled by political domination."

Like the American Medical Association and most leading practitioners and teachers of medicine, Doctor Wilson sees federal socialization of medical practice primarily as a mortal blow to the independence of private practice and the well-being of the individual physician. However, like most other medical men, he also scents the peril of permitting bureaucratic control of medical education because of the likelihood of stifling independent thinking and regimentation not only of medical practitioners, but of the public.—*Christian Science Monitor,* January 5, 1938.

HIGHLIGHTS IN CALIFORNIA'S PUBLIC HEALTH WORK IN 1937*

Many new activities in the promotion of public health have been started in California during the past year, and many old activities have been either amplified or renewed.

Of first importance is the reëstablishment of the Bureau of Venereal Diseases in the California State Department of Public Health. This was made possible by legislative enactment and approved by Governor Frank F. Merriam. In 1917, California established the first state bureau of this sort and it functioned until 1920, when lack of funds stopped its work. The State appropriation now available for venereal disease control, augmented by Social Security funds, provides for a sound program in case finding, treatment, support for public clinics, free distribution of drugs to patients who are unable to pay, education in prevention and other attributes that provide effective measures in the prevention and control of these devastating diseases.

The extensive migration of agricultural laborers into California from other states and from Mexico has necessitated the institution of special activities to control communicable diseases among such laborers and to provide protection for residents of California. These activities have covered general camp sanitation, immunization against smallpox and diphtheria, instruction in child hygiene, maternal welfare, nutrition and facilities for the diagnosis of tuberculosis. Pediatricians, tuberculosis workers, nurses, and sanitary inspectors have worked in those districts of the San Joaquin Valley, particularly, where approximately 100,000 migratory laborers have been employed during the past season. A motor-truck equipped with x-ray apparatus and other facilities for the diagnosis of tuberculosis is moved from camp to camp, where clinics for the discovery of tuberculosis cases are conducted.

Because of the various hazards connected with many industries of the State, it has been necessary to establish active operations in preventing such hazards. Various dusts, chemicals, and air pollution are factors in the production of industrial diseases. Surveys have been undertaken in the various industries and coöperative efforts with manufacturers have been developed in order to lessen the industrial hazards and thereby prevent the production of industrial diseases. A special study of carbon-monoxid poisoning in transportation is now under way.

Through the provision of public health nurses in rural counties, a more extended health service to rural residents has been provided. The addition of six women physicians to the staff of the Bureau of Child Hygiene has enabled thousands of children, living in the rural districts, to receive physical examinations which were not available to

* A report submitted to the Council of the California Medical Association on January 15, 1938, by Dr. Walter M. Dickie, Director of the California State Board of Public Health.

them before 1937. Two trailers, equipped with complete dental facilities, have enabled three dentists, added to the staff of this bureau in 1937, to examine the teeth of many thousands of children in the rural districts, provide temporary repairs, and give advice to those children who are in need of such services. Dental hygienists and a nutritionist provide educational services.

Special facilities for finding crippled children and providing them with relief for their physical handicaps have been undertaken. Clinics for diagnosis, without cost to parents, have been conducted in the counties of the State.

During the year three new full-time county health units have been added to the seventeen such units that existed in California prior to this year. The new units are in Yolo, Santa Cruz, and Ventura counties. The Yolo County unit is actually a reëstablished unit, as the health work of this county was formerly conducted upon a full-time basis.

Through the provision of Social Security funds, the State Department of Public Health has been enabled to establish, in coöperation with the University of California, a school for the training of sanitary inspectors and health officers. Candidates for such training have come from all of the western states. While the State Department of Public Health has acted mainly as sponsor of the activities conducted by this school, it has assisted directly in passing upon the qualifications of candidates, and in the provision of special training along practical lines of health administration.

No special problems in communicable disease control have been encountered during the year. Influenza of a severe type was quite prevalent during the early part of 1937, but no extensive outbreak prevailed. Public health conditions, in general, have been good throughout the year. Marriages and births have increased approximately 10 per cent over 1936.

MALPRACTICE SUIT PROBLEM IN LOS ANGELES COUNTY

Report of the Los Angeles County Medical Association Committee on Defense on December 16, 1937

Considerable time and effort has been spent by your committee during the past year, studying the problem of malpractice in Los Angeles County. We have interviewed litigants, attorneys, officials of insurance carriers, and have been interviewed by plaintiffs and defendants, and have in every way possible tried to get the viewpoint of all parties concerned.

A steadily increasing cost for insurance of this kind would almost in itself tell the story. The Medical Protective Company, which carries the major portion of malpractice insurance in California, submits the following premium rates for $5,000, one case, and $15,000 total for policy year:

State	Premium	State	Premium
California	$30	Illinois	$18
Indiana	20	Iowa	18
Kansas	18	Kentucky	18
Massachusetts	36	Michigan	18
Minnesota	27	Missouri	30
New Jersey	24	Ohio	24
Pennsylvania	16	Texas	24
Wisconsin	22		

Nebraska: $1,000 to $2,500. Premium: $20

These rates show California to be second highest, next to Massachusetts. Nebraska would head the list if a policy of the same denomination were obtainable and sold at the same rate. Your committee finds difference in underwriting expense in various companies from 26 to 46 per cent of the premium. During the last twenty-five years, about a score of companies have engaged in selling malpractice insurance in California. After a few years' experience, it was found unprofitable and the majority have withdrawn from the field, leaving only three or four still engaged in this type of business.

The three American companies writing the major portion of the malpractice insurance in California are: Medical Protective Company; Aetna; and Zurich. A fourth company—Lloyd's of London—have recently come into the field, where they are writing an indemnity contract. Lloyd's operates under the excess liability law of California. There are approximately twelve different types of policies being written by the Lloyd's in Los Angeles. There appears to be considerable spread in the premiums charged by the different brokers.

These policies are certificates written by the brokers themselves, supposed to conform in general to a master policy in England, but into which the broker can write anything he chooses. These certificates show considerable variation and are practically all limited to bodily injury, or death as a result of malpractice, error or mistake. Many lack what is commonly understood to be complete coverage.

Certain irregular groups in the healing art find it impossible to buy insurance from any American company. The Medical Protective Company reports that it has lost money in the State of California during the past five years. The latter named company has had the greatest experience in defending malpractice suits, having defended 48,000 in the United States in the last forty years. From January 1, 1936 to January 1, 1937, the Medical Protective Company paid out $1.20 for every $1 premium collected in California, and for the first six months of 1937 the outlay has exceeded the premium intake by 20 per cent. This has precipitated a premium adjustment upward. The Medical Protective Company has restricted its policyholders entirely to members of the Los Angeles County Medical Association. It has restricted its limits of coverage, believing that the high limits provide bait for "easy money seekers." This, in the opinion of your committee, makes excess liability policies such as written by the Lloyd's of London and other companies necessary.

An amendment recently passed to the California Insurance Code decrees that "a surplus broker may sell insurance only if such insurance cannot be procured from the majority of the insurers admitted for the particular class of insurance, provided the insurance is not placed in the non-admitted insurer for the purpose of procuring a lower rate than would be expected by the admitted insurer."

The State of Pennsylvania, with 12,889 doctors, records only one-tenth as many malpractice suits as the State of California with 11,542 doctors. Cook County, Illinois, has approximately one-third as many suits filed as Los Angeles County, in spite of the fact that it has approximately twice as many doctors. Massachusetts is an unusually fertile field for the filing of malpractice suits and has a correspondingly higher premium rate. The highest premium, until recently, was in the State of Nebraska, where the laws admitted the introducing of evidence that the liability of the doctor was covered by insurance. Recently, this has been changed. The company previously carrying the majority of insurance in the State of Nebraska found it necessary to withdraw from the field, and upon resumption, has limited its policies in the state to $1,000 to $2,500.

There are approximately thirty to fifty men who belong to the Los Angeles County Medical Association who cannot buy insurance in the Fort Wayne (Medical Protective) company for various reasons.

It is your committee's opinion that comparatively few malpractice suits that go to trial have merit. Approximately 92 per cent of all the malpractice suits tried in the State of California are successfully defended.

It is interesting to note that in the metropolitan centers of California the press sees fit to publicize only such suits as involve men whose names have unusual news value. Your committee believes that the newspapers appreciate the inability of the doctor to defend himself against the damaging publicity, the greater percentage of which is without merit.

The greater majority of malpractice suits in which the plaintiff's case has merit are settled out of court. It is believed that approximately 50 per cent of all malpractice cases are taken by attorneys on a contingent basis, the attorney's contract calling for 33⅓ per cent of the recovery without trial and 50 per cent with trial.

Your committee has reviewed the transcribed testimony of many of the suits tried in the courts during the past year. The committee was particularly impressed with one case in which a county medical member testifying against his brother practitioner admitted on the stand that the fee involved was the only activating motive which prompted him to assume the interest of the plaintiff in the case. Your committee has also been interested in one type of suit in which a regular practitioner of medicine has sued his brother practitioner.

The committee is also impressed with the fact that medical testimony given in court is seldom scrutinized by those

qualified to judge of its accuracy or fairness. This fact apparently allows certain individuals to assume considerable latitude in their expressions of opinion.

Your committee was particularly interested to review the testimony of a medical expert appointed by the Court under Section 1871, Code of Civil Procedure, State of California, and was impressed with the eminent fairness of this witness. Unquestionably, the ends of justice could be better served by the utilization of Section 1871 (appointment of medical experts as court officers), if the judges had the opportunity to select these appointees free from political or personal influence and provided the appointees were individually properly fitted to the task.

A review of the malpractice suits for 1936 and 1937 discloses that plaintiffs' experts number approximately thirty men, residing in Los Angeles County. Of this number in 1936, approximately 20 per cent were nonmembers and irregulars, whereas a study of the 1937 record reveals the fact that approximately 70 per cent were nonmembers and irregulars.

A study of the transcribed testimony further shows definite evidence of a tendency on the part of doctors appearing as adverse experts against their fellow practitioners to give impressive testimony without adequate careful examination into, or knowledge of the matter in hand. It is not uncommon to find gross misstatements.

Your committee takes cognizance of the fact that oftentimes counsel is doing his best to confuse the witness and trick him into saying something that he does not mean.

The figures show that approximately 66 per cent of all malpractice suits filed were against surgeons, and 33 per cent were against internists and diagnosticians.

Your committee believes that in malpractice suits, as in personal injury and many other types of suits, the average jury is often incapable of decisions based on fact rather than sympathy.

There has been a decided increase in the disposition of claims, thus reducing the number of suits where the circumstances merited such a course. Certain companies are now making a premium differential to cover certain classifications where the hazard is obviously more prevalent. They are also making a strenuous effort to educate its policyholders and assist them in avoiding the pitfalls.

The Medical Protective Company reports that the average duration of a malpractice trial in Los Angeles County is four and one-half days; that the most of defense is $175 per diem. Assuming the present rate of $32 for policy covering $5,000 to $15,000, total premium at the end of thirty years would be the equivalent of approximately five days' expense in court, provided the case was won and there were no judgment damages to pay.

Your chairman feels that we are fortunate in having as a member one who is also a practicing attorney and a member of the Los Angeles Bar Association Bulletin Committee, which committee has expressed their willingness to coöperate. It is believed that the Bar Association would look kindly upon the publication of a summarization of the views of this whole situation.

1. Your committee recommends publication in the *Bulletin* of transcribed testimony of malpractice suits tried in this county, either in whole or in part. Your committee believes this would assist materially in the enlightenment of the profession at large who would otherwise not have an opportunity to acquaint themselves with what transpires in the courts of our community.

2. Your committee recommends that there be a renewal of efforts to secure legislation requiring a bond by plaintiff when filing malpractice suits, similar to the law requiring a bond to be filed with libel suits against newspapers. Your committee believes that such legislation would eliminate many of the "spite suits" and relieve the profession of the damage of adverse publicity.

3. Your committee recommends that the doctors of medicine, both on individual and institutional bases, endeavor to improve the quality of their records.

4. Your committee recommends that the Committee on Malpractice Defense be enlarged to seven members, including the president and vice-president of the Los Angeles County Medical Association. This would divide the task of reviewing the transcribed testimony in malpractice suits and greatly facilitate the work of the committee.

5. Your committee recommends that serious consideration be given by the Council to the suggestion coming from several of the carriers of this type of insurance, namely, that the cases of malpractice filed against its members be reviewed by the Malpractice Defense Committee and the committee's opinion regarding the medical merits of the case be made available to the legal department of the defendant company; that arrangements be made by which the Malpractice Defense Committee could call in consultation from the different sections, men qualified to assist in this work.

Respectfully submitted,

MALPRACTICE DEFENSE COMMITTEE.
Harold Dewey Barnard, M.D., *Chairman*
Wendy Stewart, M.D.
Fred B. Clarke, M.D.

FEDERAL FUNDS BANNED FOR DISTRICT OF COLUMBIA GROUP MEDICINE PLAN*

Ruling on Technical Grounds HOLC Loan for Health Clinic Was Illegal—District of Columbia Legal Approach to Problem

Richard N. Elliott, Acting Comptroller General, has ruled that the Home Owners' Loan Corporation was without legal authority in loaning $37,357.65 to the Group Health Association, Inc., which maintains a health clinic for one thousand workers in Federal Government offices. The decision, however, was based on technical grounds, and does not affect the broad issue of socialized medicine, which is rapidly assuming greater importance in the United States as mass clinics spread.

Mr. Elliott's decision is simply to the effect that a federal agency has no right to use taxpayers' money for purposes other than those stipulated in laws establishing the agency in question. The decision would stand equally, it is presumed, against a group recreation center, a circulating library, or any similar activity outside the main statutory purposes of the agency. A federal department or agency, he rules, has no right to spend money for what it considers the welfare of its employees.

Therefore, the basic issue of socialized medicine remains to be considered by other authorities. Already Elwood H. Seal, corporation counsel of the District of Columbia, is examining the general legal status of Group Health Association, Inc. He is studying two questions: (1) Whether the Group Health Association is a corporation illegally engaged in the practice of medicine; and (2) whether it is operating an insurance business without being licensed as such.

On these two contentious points briefs have been filed by counsel of the District of Columbia Medical Society, attacking the Group Health Association following sharp criticisms by the American Medical Association. Officials of the Federal Home Loan Bank board defend their action in supporting the Group clinic, pointing out that it is incorporated under the laws of the District, and claiming it is "selling service."

But the acting Comptroller General's ruling takes a firm stand against diversion of funds for purposes such as the health clinic. Action of the HOLC board in turning over $37,357.65 to the clinic is described as "without authority of law," and Mr. Elliott also brands as "of doubtful legality" the "emergency rooms" or first-aid headquarters maintained by most other Government departments.

NEW LAWS SOUGHT

Senator Pat McCarran (Democrat) of Nevada, at whose request the ruling was made, says it should be followed by "specific legislation making it impossible for this to recur in Government departments. . . . No department should take upon itself authority to divert public money and the appropriating of it. . . . This stands as an example of what may be going on in departments, and should result in legislation with teeth in it."

Because of the "emergency status of the HOLC, some doubt still exists as to the precise effect of the comptroller-general's ruling. The HOLC and its group-medicine offspring have a unique corporative status, and it may be necessary to have acts of Congress to limit their use of

* See also articles in December issue of CALIFORNIA AND WESTERN MEDICINE, on page 433, and editorial comment thereon in January number, on page 4.

funds. Had the decision applied to one of the old line departments, it would have been entirely binding.

HOLC authorities, defending their action, pointed to general authorization in the law creating the corporation, and giving its board power to determine "necessary expenditures under this Act and the manner in which they shall be incurred."

Mr. Elliott, in ruling on the contention, points out that Congress has passed specific laws for the welfare of federal employees, such as retirement and compensation for those injured in line of duty. He rules that the enactment of such laws renders negative the implication that such powers are included in general statutory provisions controlling other activities. He concludes:

"It has been the long-established rule in the federal service that the functions of the agencies of the United States are restricted to those activities authorized by general or special enactments of the Congress, and where an activity involves the expenditure of money of the United States, the appropriation laws must make the moneys available therefor, in no uncertain terms, if such activity is to be accepted as lawful. Accordingly, it must be concluded in the instant matter, that the disbursements and other costs were made and incurred without authority of law."—*The Christian Science Monitor*, December 21, 1937.

MOBILIZATION ON THE MEDICAL FRONT*

[District of Columbia HOLC Experiment]

Organized physicians, surgeons, and dentists are not the sole protestants against the scheme fostered by an influential section of the Roosevelt Administration to socialize the practice of medicine, surgery, and dentistry. American taxpayers, who foot the bills for all government expenses, regular and experimental; who squirm under restrictive taxes, and groan loudly at the prospect of still others, are making their voices to be heard.

Observing the experiment by a governmental agency, the Federal Home Loan Bank Board, which appropriated $20,000 to finance the establishment of a health insurance association among its two thousand employees, and promised $20,000 more, taxpayers are asking pointedly why, in addition to paying the salaries of these federal employees, they are asked to pay from one-third to one-half of their doctors', nursing, and hospital bills.

True, the acting Comptroller General has informally held this appropriation to be illegal, but nothing has been done to halt the scheme. On the contrary, proponents of positive action by Congress grow more insistent daily.

The American taxpayer is usually inarticulate—except at the ballot box. There are, however, a few organizations whose members contribute heavily to the United States Treasury and at least one of these, the Chamber of Commerce of the United States, is strenuously opposing nationalized medicine and federal health insurance, being convinced—from a study of similar experiences abroad—that they will mean another huge bill for the public, with no compensating advantage or benefit.

* * *

Nation's Business, organ of the Chamber of Commerce, warns that the experiment, begun under Government auspices, will spread to other and eventually all federal agencies and thence to include the whole public, if not resisted and checked at the outset. This is the way the business began in Germany fifty years ago, where the budget for sick insurance rose from 660,000,000 marks in 1913 to 2,330,000,000 marks in 1929!

That proponents of health insurance are determined to establish a nation-wide federal organization, reaching from Washington down into every village and hamlet, cannot be doubted when their utterances are examined.

Dr. Thomas Parran, Surgeon-General of the United States, appealed to the Association of Life Insurance Presidents in New York a few days ago to participate in the plan. Hitherto the insurance companies have looked coldly upon any governmental scheme for taking over their work, as well as that of the doctors. Doctor Parran said:

I propose that a new and result-getting national health program be built upon the skeleton forces we now possess; that we mobilize a health organization covering every community in the country under local control, with State supervision and Federal leadership. . . .

* * *

The Home Loan Bank Health Association experiment is called voluntary, but the employees did not inaugurate it; it was established by the Government agency which allocated public funds to provide part of the cost and assigned employees to administer its affairs. On that basis, *Nation's Business* estimates, the taxpayer will be defraying about one-half the expense.

A clinic with a staff of fifteen has been set up, including six or seven physicians, and complete medical and surgical service, hospitalization, nursing, laboratory tests, ambulance facilities, and special examinations, which are to be supplied to members who pay from $2.50 to $3.30 a month.

* * *

No one can blame the employees for desiring to escape from doctors' bills. Anyone who has gone through the experience of family illnesses and operations understands how savings often thus are wiped out and debts accumulated. Inevitably, if the Home Loan Board group succeeds in getting the taxpayers to foot one-half their medical bills, other Government employees will set up a clamor for similar aid. Indeed, this is one of the demands of the United Federal Workers of America, an affiliate of the C. I. O., which seeks to organize the 800,000 civilians in federal employ.

The next logical step, should all Government employees obtain "taxpayer aid" on their doctor bills, would be a public demand—encouraged, of course, by sponsors of socialized medicine—for Uncle Sam to take over doctoring on a national scale.

All these are recognized evils, but they do not primarily interest the taxpayer. He thinks in terms of a possible cash outlay of at least $10 a year for each of 800,000 federal employees, an $8,000,000 annual budget. And if he is obliged to pay part of everybody's doctor bill and support another army of bureaucrats besides, he might as well put a mortgage on the old homestead and commence to cash in his insurance policies.

* An article by Malcolm Bayley in *Christian Science Monitor*, January 6, 1938.

PUBLIC HEALTH EXHIBIT: NEW YORK WORLD'S FAIR*

Exhibits of unparalleled scientific and educational value, portraying menaces to the physical welfare of mankind and the safeguards against them, are to be presented in an entirely new way in the Medicine and Public Health Building of the New York World's Fair, 1939, it was announced recently by Grover A. Whalen, President of the Fair Corporation.

Dramatic presentations will be made to show, among other things, the latest scientific knowledge of cancer, diabetes, blood diseases, anemias, pneumonia, allergy, epidemiology, heart disease, and milk control.

Applications of sponsors for all these exhibits have been approved by the Fair's Advisory Committee on Medicine and Public Health, of which Dr. Louis I. Dublin is Executive Committee Chairman and Homer N. Calver, Secretary. All save milk control will be presented in the Hall of Medical Science. Milk control will be displayed in the adjacent Hall of Public Health.

Hall of Man.—The Health Building is now nearing completion on the site at Flushing Meadow Park. The Hall of Man, the interior of which is cathedral-like in design, is to dominate the building. The sound of a persistent, measured pulsation, low but audible to every ear, will permeate this vase chamber. Mysterious at first, it will be discovered as the heart beat of an imposing, 18-foot figure of a man standing at one end of the long hall. This model, transparent and lifelike in every proportionate detail of physiological construction, is to disclose the intricacies of every organ with which Nature has equipped the adult human creature. It is expected to be a revelation to countless visitors who never before have seen themselves in just this way.

Surrounding the figure, similarly transparent life-size models will illustrate the processes of respiration and di-

* This article is given space because the 1939 Golden Gate International Exposition, San Francisco, is likewise making plans for a large public health exhibit. See January, 1938, issue of CALIFORNIA AND WESTERN MEDICINE, page 65.

gestion, the functions of the eye and ear, the mysteries of growth and reproduction.

"We, the People."—Another feature of the hall is to be provided by an exhibit, entitled "We, the People." It will include a dramatic presentation of the various races and nationalities of the world which have contributed to make America the "melting pot." A large map is to demonstrate, by moving figures, the flow of population to every part of the United States to bring about the creation of the nation of the present.

"Vitameter."—Here also a large vitameter, similar to the speedometer in a motor car, will register the principal events of human life: birth, marriage, and death. The mechanism, set to the scale of the average week in the United States, may show on a Tuesday, for instance, the number of births to be 12,000, and on the following Thursday may register the number as 21,000 at noon and 24,000 at night. In other words, just as the cumulative mileage is recorded on the speedometer of a car, the vitameter will show the cumulative number of births from the first day of the week through the seventh. In similar fashion, the number of marriages and deaths are to be shown. One point the mechanism will emphasize is that the birth registration is more rapid than that of death.

Tuberculosis.—The exhibit on tuberculosis in the Hall of Public Health in another part of the building will be unusual and promises to arouse universal interest. It will provide a great deal of information about the disease quite unknown to the layman. There will be representations, for example, of the normal lung and of one afflicted with tuberculosis, so that visitors may see just how the diseased tissue differs from the healthy. X-ray pictures will also reveal it, and a portrayal of the tuberculin test reveal its efficiency in showing the presence of disease.

As the sufferer from tuberculosis does not always reveal that condition in his outward appearance, visitors to this exhibit will be asked to select from a large number of photographs of individuals the ones he thinks are tuberculous. It is expected that the visitor will find his selections all wrong in many instances.

Hospitals.—One section of the building's Hall of Medical Science is to be devoted to hospitals and organized care of the sick to show how many departments and persons are involved in service to an ailing individual. The multiplex details of hospital administration are to be revealed by lifelike figures centering about a patient in a hospital cot. There will be the doctor and the nurse, the only ones of the hospital staff with whom he has contact. But grouped elsewhere in the dramatic model will be shown the departments which provide service for him: the admission office, the laboratory, pharmacy, housekeeping, dietary, laundry and light and power agencies.

Demonstration of the financial side of the hospital is to be effected graphically by having the four legs of a hospital cot made of stacked silver dollars. Of these dollars, 60 per cent come from the patient, 30 per cent from state, county, or municipal government, and the 10 per cent remainder from endowment. Fifty per cent of this income is spent for food and equipment. What the piled dollars are to demonstrate is that the cot cannot stand level if the 30 per cent or the 10 per cent be missing.

There will be an animated story of persons going through hospitalization—old and young, rich and poor, youths and babies—from admission to assignment to ward or room, preliminary examination, the calling in of specialists in special cases. An operating room will be shown, with the surgeon in white gown and mask, gloved with instrument in hand, with attendant nurses. Next will be a representation of a patient's period of convalescence and, lastly, discharged from the hospital— a well, whole being.

Flanking this exhibit there will be others of roentgenology, anesthesia, and analgesia.

The Teeth.—"Living teeth as living tools," is the theme of the exhibit of dentistry and oral hygiene. In the foreground of the exhibit, a question and answer board will present the typical queries of most people, such as: How often should I brush my teeth? What good does it do to go to a dentist? What happens to me if I neglect my teeth? The visitor who seeks an answer need only push a button adjacent to the question and it flashes before him.

The transparent model of a man will show, by moving lights in series, just how infection from a tooth is carried to various parts of the body, to joints and the heart, indicating that bad teeth may seriously impair the general health. Another exhibit will be in the form of a huge mouth into which visitors may walk and find themselves surrounded, above and below, by rows of teeth. It has been suggested that the floor of this exhibit be of soft rubber in order that the entering visitor may seem to be walking on the model's tongue. The teeth in the exhibit are translucent, a light from below showing that an infected spot may not be visible by tooth inspection with a mirror. Illumination will bring to light the nerve and blood circulation of the individual tooth.

A small model of a baby's mouth is to be provided with a lever which, when manipulated by the visitor, will cause teeth actually to appear in the order of their normal growth in the infant's gums. A panel will illustrate the correct and improper growth of teeth, and there will also be graphic portrayal of the foods necessary for proper care of the teeth.

Health Departments.—Work of the Health Department of a community is to be represented on panels showing the activities during every hour of the day of inspectors and public nurses.

Coöperating Agencies.—Special committees, composed of distinguished medical men and public health experts, are developing plans for the fifty sections included in the medicine and health building. They are giving their advice without remuneration of any kind. There will be only one presentation of each subject exhibited. Already a number of these exhibits have been sponsored and work upon them is well under way.

The New York City Cancer Committee will sponsor the exhibit on Cancer, which is being developed under the direction of the following committee: Dr. Francis Carter Wood (chairman), Dr. John C. A. Gerster, Dr. Ira I. Kaplan, Mrs. Robert G. Mead, Col. Frederick J. Russell, Miss Katherine Faville, and Mrs. Francis J. Rigney.

Eli Lilly & Company will sponsor the exhibits on diabetes, and blood diseases and anemias. The exhibit for the section on diabetes is being developed under the direction of a committee, consisting of Doctors James Ralph Scott (chairman), Charles Bolduan, William Ladd, Herman O. Mosenthal, Russell C. Wilder, Elliott Joslin, Frederick Williams, Albert A. Epstein, M. M. Weaver, and Miss Grace Anderson.

The exhibit for the Section on Blood Diseases and Anemias is being developed under the auspices of Prof. Randolph West, Dr. Paul Reznikoff, Dr. Cornelius P. Rhoads, Dr. E. B. Krumbhaar, Dr. Nathan Rosenthal, and Dr. M. M. Weaver.

Lederle Laboratories, Inc., will sponsor the exhibit on pneumonia, developed under the supervision of Dr. Rufus Cole (chairman), Doctors Roderick Heffron, Peter Irving, Maxwell Finland, Jesse G. M. Bullowa, Russell L. Cecil, Edward S. Rogers, E. F. Roberts, and Miss Alma Haupt.

Lederle Laboratories, Inc., will also sponsor the exhibits on allergy and epidemiology under direction of the following committees: On allergy, Doctors Francis Minot Rackemann (chairman), Robert A. Cooke, Matthew Walzer, Maximilian Ramirez, Marion B. Sulzberger, Joseph Harkavy, Ranklin Stevens, and E. F. Roberts. On epidemiology, Doctors E. S. Godfrey (chairman), Clarence Scamman, George Ramsey, William Best, Charles Vivian Akin, W. H. Frost, and E. F. Roberts.

Ciba Pharmaceutical Products will sponsor the exhibit on heart disease, which is being developed under the guidance of the Heart Disease Committee which includes: Doctors A. E. Cohen (chairman), E. P. Boas, L. A. Connor, J. H. Crawford, C. De la Chapelle, Stuart Hart, James B. Herrick, E. B. Krumbharr, E. M. Landis, Robert L. Levy, A. G. Macleod, C. McEwen, Hugo Roesler, J. M. Steele, Homer S. Swift, P. D. White, Harold J. Stewart, and Miss Elizabeth McKenzie.

Cherry-Burrell Corporation will sponsor the exhibit on Milk Control, developed under the auspices of the following committee: Doctors Milton J. Rosenau (chairman), Alec N. Thomson, Paul B. Brooks, Leslie Frank, William B. Palmer, Samuel Abraham, John G. Hardenbergh; Prof. J. M. Sherman, and Walter Von D. Tiedeman.

Applications for other sections are pending before the committee which has planned a unified and coördinated exhibit on Man and His Health.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 2, February, 1913

From some Editorial Notes:

The Legislature.—At the time of writing it is impossible to say just what has been proposed in the way of medical legislation, though some things are quite apparent. The usual attempt is to be made to secure special boards of examiners in almost every sort of freak cult. A number of bills have been drawn which may or may not be introduced; one of them provides an entirely new medical law on an entirely new plan, but no copy of the bill has as yet come to our attention. Another proposed law provides for separate boards of examiners for regulars, homeopaths, eclectics, osteopaths, naturopaths, and divine healers!

* * *

Medical Building.—Have you thought anything about that suggestion in the last *Journal* as to the county society owning its own building? It can be done by a good many—if not most—of the county societies in California. You all pay rent to somebody; why not pay it to the county society? It is merely a matter of finance and of getting together, and the getting together, in some places, seems to be the hardest part of the problem.

From an article on "Some Factors in Habitual Constipation," by Raymond Russ, M.D., San Francisco.—The center of surgical discussion shifts from time to time. The brain, the neck, the thorax, occupy in turn the circle of the spotlight, which may be switched at any moment to some other portion of the stage of endeavor. Surgery, constantly trying to increase its scope, has fads and fancies. The opening of a new field is always followed by a stage of overenthusiasm, and sometimes reckless and ill-considered operating. Concomitant causes are lost sight of in the presence of what is thought to be a newly evolved principle, so desirous are we of reducing our asset of painful experience to the proportions of absolute, scientific fact.

From an article on "Feeding in Later Infancy," by H. H. Yerington, M.D., San Francisco.—During the past six or eight years, probably no subject in medicine has received more attention than infant feeding, and with numerous schools advocating so many various methods, the family physician, if he tries to keep up with the literature, finds himself in a hopeless tangle.

From an article on "Dietetics from a Modern Standpoint," by Annie W. Williams, M.D., Hayward.—In this age of searching analysis, keen observation, thorough research, extensive and exhaustive laboratory experiments, practical demonstrations and laborious investigations, dietetics, the science or study and regulation of the diet has not been overlooked, but has received its full and much-needed share of attention. World-wide questioning is being directed to the disquieting fact that eating just for self-gratification, the good taste and flavor because you happen to like it, and to satisfy a pampered, over-cultivated and oft-times, more or less, perverted appetite, is possibly not all it should be.

From an article on "The Technique of the Removal of Foreign Bodies and New Growths from the Esophagus," by W. P. Millspaugh, M.D., Los Angeles.—This subject is a little bulky for a ten-minute paper, and I shall begin immediately to use the pruning shears. That portion of it referring to new growths is an unknown field to me, and I

(Continued in Front Advertising Section, Page 16)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

"The State District Court of Appeal issued a writ of mandate today requiring Superior Judge J. J. Van Nostrand of San Francisco to prepare and file a finding of facts in a case involving the rights of chiropractors. Chiropractors are seeking a comprehensive court interpretation of the law pertaining to their profession. M. James McGranaghan, a chiropractor and lawyer, in April, 1935, filed application for a declaratory judgment to determine what rights he could exercise under his license as a chiropractor. The California Drugless Physicians' Association and a number of Los Angeles chiropractors intervened in the action. In September, 1935, Judge Van Nostrand issued a memorandum opinion, but stated he did not regard a finding of facts as necessary. Application for the writ of mandate was made to the State District Court by Attorney-General U. S. Webb." (Fresno *Bee and Republican,* December 11, 1937.)

"Local doctors were warned yesterday to lock their cars and to refrain from leaving medical kits in them while making calls or visiting hospitals, due to a new outbreak of thefts in Marin County. According to word received here yesterday from Police Chief Sabin D. Kane of San Rafael, kits containing drugs and equipment worth more than $300 have been stolen from physicians' cars in that city during the past few days. Included in the equipment stolen were a complete blood-pressure machine, two sets of syringes in a leather case, ear and throat probing instruments, a quantity of morphine, and two sets of hypodermic needles." (Santa Rosa *Press-Democrat,* December 24, 1937.)

"Medical kits of five Bakersfield doctors have been stolen from their automobiles during the past several days, according to city police. All but one have been recovered. . . . Officers believe the thefts to be the work of a dope addict." (Bakersfield *Californian,* December 30, 1937.)

"A prominent Pasadena eye, ear, nose and throat specialist, Dr. H. M. Griffith, whose trial in Los Angeles County courts in 1933 over the shooting of a banker friend who allegedly defrauded him of over $50,000 was interrupted when he was declared mentally incompetent, appeared before the Mendocino County Superior Court Friday. On a writ of habeas corpus, the doctor asked for release from the Mendocino State Hospital, where he has been confined since that time, so that he might return to Los Angeles County to defend himself in the resumption of the criminal case against him. . . . Two deputy district attorneys from Los Angeles County, Hugh McIsaac and D. J. O'Leary, were on hand to present their case, urging that the man had not recovered sufficiently from his insanity to offer aid to his counsel in his defense. . . . Doctor Griffith, a graduate of George Washington Medical School in St. Louis, and a normal-appearing gentleman, somewhat gray and wearing horn-rimmed spectacles, testified for himself concerning the shooting of a Mr. Hubbard, vice-president of the Citizens Savings Bank of Pasadena, with whom he had entrusted his funds. In two civil trials he had gained no satisfaction for the fraudulent manipulations of his money by Hubbard, which included a check for $52,500 from the city of Pasadena for property condemned for Civic Center purposes. He testified that he felt there had been tampering with the jury in the first trial, while the second had been decided on a technicality. These beliefs, with others, were listed by Deputy District Attorney McIsaac of Los Angeles as 'delusions' and adequate proof of Griffith's unsound mental condition. . . ." (Ukiah *Redwood Journal,* December 11, 1937.)

(Continued in Front Advertising Section, Page 24)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

representing himself as a famous physician who was collaborating with a London doctor on a new health plan. His criminal record revealed that he was once arrested in Milwaukee in 1926 and sentenced to a year in prison for forgery; that he later was sentenced to the Indiana State Reformatory for from one to ten years, and following his release there served eighteen months in a California prison for fraud." (Santa Rosa *Press-Democrat*, December 19, 1937.)

"Dr. Paul Eid's efforts to regain his liberty by writ of habeas corpus from the Superior Court failed today in Redwood City when Judge Maxwell McNutt ruled that the writ was not proper legal procedure. Doctor Eid, young Burlingame physician, was jailed November 3 on charges of indecent exposure filed by Burlingame police. In his petition for the writ, he alleged he had been promised the case would be dropped if he pleaded guilty and left the city. From the bench, Judge McNutt advised Doctor Eid's attorney, Bernard P. Sharon of San Mateo, to proceed with a writ of coram nobis—an order vacating judgment because of error of fact not known to the judge—in the lower court. . . . If the writ is denied, Sharon will appeal to the Superior Court, he said. If it is granted, Doctor Eid will be given an opportunity to plead not guilty and go to trial in the Burlingame court." (Burlingame *Advance-Star*, December 8, 1937.)

"Eugene J. Rinaldo, convicted last April of practicing medicine without a license and sentenced to six months in the county jail, today was placed on two years' probation by Municipal Judge Harold B. Landreth. Rinaldo, one-time candidate for the Board of Education, appealed the original sentence, which also carried a fine of $500, but the appellate court upheld the conviction. Rinaldo paid the



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$500 fine today before Judge Landreth, who on recommendation of the probation officer, granted probation." (Los Angeles *Herald and Express,* December 14, 1937.)

"Aris Amaral, 39-year-old self-described Arabian minister, was arrested by Los Angeles police yesterday at 400 South Rampart Boulevard for San Bernardino authorities. He is charged with grand theft. The arrest followed that of his asserted partner, John Pritchard, alias Rev. Korda van Ormond, in Houston, Texas. Pritchard now is awaiting trial in San Bernardino on a similar charge. Both were indicted by the San Bernardino County Grand Jury. The complainant is Mrs. Belle Shinkle of Redlands, who charged she purchased a half-interest in their San Bernardino fortune-telling establishment last May for $3,700. Her money, she understood, was to be used to launch radio horoscope readings. On her return from a trip East, she told Sheriff Shay, she could find neither her partners nor their fortune-telling enterprise. Amaral's bail was set at $8,000 and Sheriff Shay was notified of his arrest. Several years ago Amaral founded the Temple of Isis in the Hollywood hills, which was closed after he was convicted of violating the State Medical Practice Act." (Los Angeles *Times,* December 15, 1937.)

Federal Food and Drug Administration Lists Recent Court Terminations.—The Federal Food and Drug Administration of the United States Department of Agriculture has issued a statement of criminal actions recently terminated. The actions, brought under the authority of the Food and Drugs Act, cover a wide variety of offenses, and are so many that the current statement merely catalogues them into various categories. . . .

Cases Involving Drug Products

Cases involving drug products that did not conform to the represented standards were terminated as follows: Frank F. Lefkoff, trading as Authorized Brands, Atlanta, Georgia, turpentine, fine $25; Columbia Medical Laboratories, New York, ephedrin hydrochlorid, $50; Connecticut Chemical & Disinfectant Co. (Edward T. and Cyril F. Ahern), New Haven, Connecticut, aromatic spirits of ammonia, $25; Intra Products Co., Denver, Colorado, ampoules phenobarbital sodium (unsterile) and ampoules Pituipost, $300.

Meyer Bros. Drug Co., St. Louis, Missouri, phenolphthalein, and tincture of belladonna leaves, $400 and costs; Price Drug Co., Inc. (Samuel and Philip C. Thomas), New York, three ointments, paid fines of $225 and suspended fines of $225; Roma Extract Co. and Joseph Graceffa, Boston, Massachusetts, citrate of magnesia, $20; Shores Co., Inc., Cedar Rapids, Iowa, Epsom salt tablets, $25 and costs; Alva F. Watkins Co., Jackson, Michigan, six pharmaceutical preparations, $500; and Zenith Drug Co., New York, boric acid, $20.

(Continued on Next Page)

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● MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

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It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is *marked* drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

A Natural Mineral Water
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MANGANESE	1.3 parts per million
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NITRATE	0 parts per million
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Authorities say: The value of Vichy Celestins as an adjuvant in hepatic and gastric affections, has long been acknowledged in medical literature. Its use is indicated both in their treatment and dietetic management.

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(Continued from Preceding Page)

Patent Medicine Cases

Patent medicine cases during the three-month period involved twenty-nine shippers. The terminations were: Alpha Laboratory, Inc. (Dr. and Mrs. Frank R. Braune), Chicago, Illinois, "Lacta Kaolin" preparations, falsely and fraudulently represented as treatments for dysentery, cholera, and stomach disorders, fine $110; Bleecker Foster, Inc., St. Paul, Minnesota, "Flame Liniment" for rheumatism, $5; G. F. Foster Company, St. Paul, Minnesota, "Simba," $20.

Creotina Chemical Co., Belleville, Illinois, "Sanadon," for infectious diseases of the mouth and gums, $200 and costs; Clyde Collins Chemical Co., Memphis, Tennessee, three "Puritan" brand preparations for rheumatism, kidney and bladder troubles, malaria, dysentery, cramps and other conditions, $400 and costs: Eby Remedy Co., Marengo, Iowa, "Eby's Swine Medicine," $25 and costs.

Erie Laboratories, Cleveland, Ohio, six preparations for hay fever, indigestion, bladder disorders, and other conditions, $150 and costs; Fairey Wholesale Drug Co., Orangeburg, South Carolina, "Fairey Oil" for neuralgia, rheumatism, sore throat, $25; Wallace N. Key, Arthur E. Fest and Benjamin H. Hickman, operating as Foundation Labs., Inc., Chicago, Illinois, "Rx 444 for Males" and "Rx 333 for Females," rejuvenation treatments, fine $600 and costs; E. Fougera & Co. and Tam Co., New York, "Tam," represented as made of "natural laxative fruits," as containing "no drugs," and as a "jam," when in fact it contained senna leaves and other plant laxatives (the product was also moldy), $50.

Gall-Flo Labs., Inc., Cleveland, Ohio, "Gall-Flo," for ailments of livestock, $100 and costs; Heinrich Chemical Co., Minneapolis, Minnesota, seven preparations for rheumatism, dysentery, mouth infections, and poultry diseases, $45; Hi-Test Labs., Inc., Cleveland, Ohio, "Dr.

(Continued on Page 38)

CANNED FOODS IN THE CONTROL OF SUBACUTE DEFICIENCIES OF THE ANTI-PELLAGRIC FACTOR

As a result of his classical researches, Goldberger first proposed the name "Pellagra-Preventive Factor" for that component of the vitamin B complex which he found effective in the prevention of human pellagra. Subsequently, the terms vitamin "G" and sometimes vitamin "B_2" were used to designate this effective factor. However, until biochemical research has conclusively established its identity, it is now apparent that we had best return to Goldberger's original designation for that entity which protects the human against pellagra.

In contrast to the other vitamin deficiencies, cases of severe deprivation of the anti-pellagric factor are not uncommon in certain regions of the United States. It is also known that if the intake of food be drastically restricted for some reason—alcoholism, for example—pellagra may be encountered in localities in which the discase is not endemic (1). For these reasons, it is not unreasonable to suspect that subacute or latent deficiencies of the P-P factor may also be existent in this country.

In the absence of typical dermatitis, available means for the diagnosis of deficiencies of the anti-pellagric factor are not entirely satisfactory. The practitioner must rely upon a variable group of less specific symptoms such as glossitis, diarrhea, digestive disturbances, and nervous and mental disorders. However, consideration of these symptoms along with an evaluation of the diet upon which the subject had been maintained, may permit the conclusion that suboptimal intake of the P-P factor should be suspected.

The treatment of severe or perhaps even the mild manifestations of this dietary deficiency may require intensive therapy with food products or preparations known to be rich in the pellagra preventing factor. However, prevention of pellagra and maintenance of the cure appear to be largely matters of dietary regulation. In this connection, commercially canned foods deserve particular mention.

Goldberger and his associates directed considerable attention to evaluation of the pellagra-preventive powers of common foods. The values of foods, many of them canned foods, in the prevention of pellagra have been determined (2) by investigations in which human subjects were used.

In view of these facts, it is apparent that certain commercially canned foods will prove reliable, convenient and economical in the formulation of diets calculated to protect against mild or severe deficiencies of the P-P factor.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.



1. 1937. J. Am. Med. Assn. 108, 15.
1935. Ibid. 104, 1377.

2. 1934. U. S. Pub. Health Rpts. 49, 755.

This is the thirty-fifth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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All Owl Stores have modern and fully equipped pharmaceutical departments.

(Continued from Page 36)

Grabill's Prescription," a product containing cinchophen, for rheumatism, sciatica, neuralgia, lumbago, sore muscles, neuritis, arthritis, and gout, $100 and costs; Indian Laboratory Co. (Antonio and Emelia B. Prieto) Laredo, Texas, "Tonico Trieto" for anemia, $100.

Lawrence-Williams Co., Cleveland, Ohio, "Lawrence Caustic Balsam," for ailments of horses and cows, $200 and costs; Dr. Leonhardt Co., Buffalo, New York, "Hem-Roid" for piles, $200; National Products Co. (W. F. Ashby and Robert G. Branham), Forth Worth, Texas, "Odo-Go" for pimples, ulcers, and halitosis, $250: W. M. Olliffe, Inc., New York, "Dr. Jacob Becker's Celebrated Eye Balsam" for granulated lids, sty, and pinkeye, $25.

S. Pfeiffer Mfg. Co., St. Louis, Missouri, "Gold Medal Cold Capsules," "Alpha Cold Capsules," "Gray's Cold Capsules," $300 and costs; Rex Drug Co. (Lewis Podrofski and William Jansen), Chicago, Illinois, "Perio Pills," "Improved Hygienic Powder" and "Rex Pep-Tone Pills," $75; Sanovaper Labs., Inc. (Ethelbert K. Walker and Gordon A. Guthrie), Huntington, West Virginia, "Dexene," for diabetes, $50; Shores Company, Inc., Cedar Rapids, Iowa, "Mother Beach Stomach Tablets," below-standard quinin sulfate, and a liniment, $50.

Stephens Mfg. Co., Fort Worth, Texas, "Eggstractor," for making hens lay, $300; Sulphur Products Co., Inc., and Wilfred S. McKeon, Greensburg, Pennsylvania, "Liquid Sulpho-O" for poultry ailments, $20 and costs; Guy S. Vanderlinde, Muskegon, Michigan, "Van's Magic Oil," for nervous and inflammatory diseases and rheumatism, $50.

Van Patton Pharmaceutical Co., Inc., Chicago, Illinois, "Allimin," for high blood pressure, $75; Eugene Hessel (Vita Labs.), Philadelphia, Pennsylvania, "Oil de Vita," "Oil de Vita Salve," and "Snuffly," fine $50 and one day in jail; and Western Labs., Inc., Chicago, Illinois, "Trask's New Treatment for Constipation," "Van Ogden Gargle," and "Van Ogden Wonderful Liniment," $25 and costs.

Fads Travel Faster Than Facts.*—Fads abound in this scientific age and thrive even among the intellectual. At times it seems that in order to protect society, faddism should be listed among the infectious maladies and the faddist put in isolation. Many are so susceptible that even slight exposure results in a period of distress. In this day of consumer protection it might be wise to have health officers ferret out faddists just as they pursue scarlet fever and mumps. A purple placard on the doors of victims' homes might prevent dissemination and exposure of the immature and unscientific and show the community that more than ordinary precautions must be taken to prevent the spread of faddism.

But speaking seriously, faddists are a problem. Food faddists seem most numerous. Great faith is placed in unusual diets which eliminate certain foods altogether, restrict combinations said to be incompatible or inharmonious or stipulate huge excess of other food essentials. Rare it is to find a person who relishes every combination, eats every protein, or who does not insist on a vitamin or mineral concentrate or carbohydrate. Since an occasional one benefits from excessive injection of vitamins, unusual diets are made to sound plausible to others. Unfortunately, certain physicians succumb and prescribe the unusual and spectacular. They justify the treatment by reasoning that if drugs are not indicated and that if the diet does the patient no harm, it serves the purpose better than psychiatry. Unfortunately these diets are often passed on to others who practice self-diagnosis and the public believes that they have particular merit.

But physicians deserve little blame for most food fads. People with something to sell—either books, lecture tickets, cooking equipment, or unusual foods that bring high profits, are often responsible. Advertisers whose statements imply rather than state untruths are the worst offenders. It is easy to see how fads get a following. All of us dislike

* By Jennie I. Rowntree, Professor of Home Economics, University of Washington.

(Continued from Page 40)

Chesterfields satisfy millions



They'll give you
MORE PLEASURE

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A General Hospital With Accommodations for Three Hundred Patients

And Operating THE MEDICAL BUILDING, 909 Hyde Street

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Samples and formularies upon request

PHYSICIANS FORMULA COSMETICS, Inc.

3823 Wilshire Boulevard — **Los Angeles, California**

(Continued from Page 38)

being back numbers, and nothing is more feared today than loss of health. The cost of medical care, the possible loss of position and of economic security have made everyone alert to accept any suggestion said to prevent illness, whether the preventive consists in cooking in a particular metal, alkalinizing diets, or eating only raw foods.

With the public health-conscious most foods have come to be sold for their health giving rather than their attractive qualities. The health-mindedness is often increased by well-meaning but short-sighted teachers. In many schools vitamins and minerals are made to seem like magical little things that prevent illness, lessen dental bills, and insure buoyant health. Consequently, any food containing vitamins and minerals in any amount appears to have merit, little or much it matters not. These teachers have thus harrowed and cultivated the mental soil until it is ready for any seed sown by the propagandist without realizing the results.

It is high time that both minerals and vitamins were put in their proper place as essential to good nutrition, but never magical in their effects in the human diet. To have magical effects they must have been totally lacking previously. If a more generous provision improves the health, the patient admits an inadequate diet originally. We should have more pride than to cast such a reflection on the family menus and enough common sense to improve them with ordinary foods.

More emphasis in schools should be placed on the amounts of minerals and vitamins found in ordinary foods as compared with the accepted requirements of these food essentials. In other words, science should be brought down to earth. To the public, science seems magical and beyond comprehension because no simple basis is given them for interpreting and evaluating advice so generously given on the radio, in magazines, and by neighbors.

Human beings do not like to be fooled. They may be lazy about reasoning or fearful of their own conclusions because science seems complicated; therefore, they accept pronouncements which are made cleverly, convincingly, and, as far as they are able to judge, authoritatively. A scientifically trained, honest research worker or physician cannot speak as conclusively because he sees many sides and aspects of the problem which prevent a finality in his thinking. How can people learn that absolute certainty almost always bespeaks the quack!

Unquestionably, all like to believe that quick cures which require little effort on our parts and no unpleasant changes in our regimens are possible. Many of us crave a little attention and sympathy, and a spectacular diet answers the purpose.

The middle-aged are, of course, most susceptible. With youthful buoyancy departing, figures widening, digestive ability slowing down, they like to believe that rejuvenation is possible. Furthermore, the middle-aged pride themselves on their youthful open-mindedness, often not distinguishing between open-mindedness and gullibility. Ready acceptors of new ideas are often agitated rather than educated by what they hear and read. How people can believe that any common article of diet eaten with other foods or separately for hundreds of years can cause poisonous "acid" products, explosive reactions or impair society's vitality is difficult to understand. The explanation, perhaps, lies in the fact that they expect modern scientific research to reveal startling facts. Being untrained, they have no fund of information with which to judge the various pronouncements they hear and see.

Fads travel faster than facts because explanations are simpler; because fads beget more hope and are often pleasanter to believe than facts; because fear of expensive illness sometimes numbs the intelligence; and because science has grown so fast that it has fallen short in explaining and applying known facts to the everyday problems of man.

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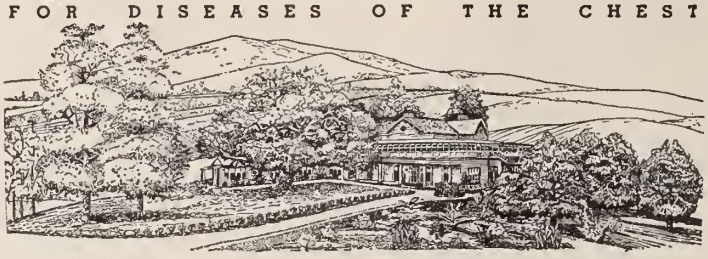
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Social Security Program Report on Advances in 1937. Nation-wide operation of the Social Security Act has been achieved in 1937 for the first time, according to a year-end statement issued today by Arthur J. Altmeyer, Chairman of the Social Security Board. "It is no longer necessary," he declared, "to discuss the Act in terms of its promises. Today the Social Security Board is able to report on nation-wide achievements in public assistance to the needy, old-age insurance, and unemployment compensation."

In summarizing the year's progress, Chairman Altmeyer stated that more than 36,000,000 wage-earners now have social security accounts under the old-age insurance program; it is estimated that approximately 21,000,000 workers are employed in jobs covered by the approved unemployment compensation laws of all the states, and over 2,100,000 of the needy—the aged, the blind, and dependent children—are receiving regular allowances from federal, state and local funds in every state but one. Among other outstanding developments, he cited particularly the Supreme Court decision, handed down on May 24, upholding the constitutionality of the Act's social insurance provisions, and the preparation for the payment of unemployment compensation benefits beginning January, 1938, in twenty-one states and the District of Columbia.

In addition to these major advances in the programs administered by the Social Security Board, Mr. Altmeyer noted that the five parts of the Act directed by other Government agencies—public health, vocational rehabilitation, and three child-welfare services—are also in effect on a substantially national basis. He pointed out that much of the credit for the rapid development of the Social Security Act, in the less than two years since it became effective in February, 1936, is due the states, since they must both initiate and administer all programs except old-age insurance. . . .

Mr. Altmeyer reported that on December 1, 1937, the funds standing to the credit of the twenty-three states which will be paying unemployment compensation benefits in January amounted to more than $400,000,000; and that those credited to the thirty-one states to pay benefits before the close of 1938 came to nearly $500,000,000. He reported also that the total amount of federal funds appropriated to the old-age reserve account now comes to some $690,000,000. Benefits under these two insurance programs are being paid from special accounts in the United States Treasury, the unemployment trust fund and the old-age reserve account, respectively. He called attention to the fact that these funds may be expended only for the specific purpose for which each is intended and that "the law requires all social insurance funds to be invested in Government obligations, the safest investment in the world.

(Continued on Page 48)



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(Continued from Page 46)

Workers can thus be sure their benefits will be paid when due."

Concluding his review of the year, Mr. Altmeyer stated that accomplishments during 1937 give assurance that greater progress will be made in the future. "The Social Security Act in its present form," he said, "is far from perfect or final; it will undoubtedly be improved and extended as we learn from experience. But by 1938 there can be no question that the American people have set their faces in the direction they propose to go. Nothing can stop their advance toward social security for themselves and for their children."

A generation or more ago, men and women commonly lived out their lives according to the die cast in the days of their youth. Training received in early years had to suffice for whatever demands might later arise. Experience, to be sure, added value. However, something was likely to be lost, for mental powers and modes of skill deteriorate through disuse. The idea of renewing or increasing one's powers in mature life was seldom entertained. Moreover, such a procedure was not supported by public sentiment. Any grown-up man who might seek some kind of schooling would have been regarded as queer. And to be thought queer was, of course, to be "in a parlous state." Nowadays, fortunately, people are coming to view these matters differently. It is no uncommon thing for a man to review, extend, and bring up to date what he has once learned, to acquaint himself with a new field of ideas, to submit himself to a new discipline, or to learn a new art. The die cast in youth does not necessarily doom one to a single, narrowing path.—Leon J. Richardson.

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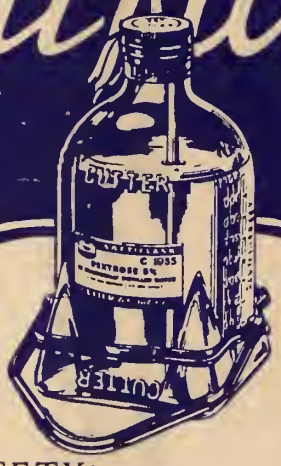
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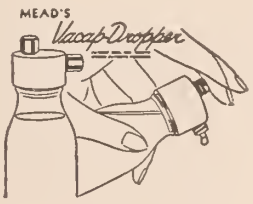
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William H. Kiger (1940), 911 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

Morton R. Gibbons (1938), Union Square Building, 350 Post Street, San Francisco.

T. Henshaw Kelly (1939), 830 Medico-Dental Building, 490 Post Street, San Francisco.

Junius B. Harris (1940), Medico-Dental Building, 1127 Eleventh Street, Sacramento.

Standing Committees

Executive Committee

The President, the President-elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Chairman of the Committee on Public Relations, the Past President, the Secretary-Treasurer and the Editor. (Karl L. Schaupp, chairman; Frederick C. Warnshuis, secretary.)

Auditing Committee

O. D. Hamlin	Oakland	1938
T. Henshaw Kelly	San Francisco	1938
Karl L. Schaupp (Chairman)	San Francisco	1938

Members of the Auditing Committee are appointed each year by the Chairman of the Council.

Committee on Associated Societies and Technical Groups

Edwin L. Bruck	San Francisco	1938
William H. Geistweit	San Diego	1939
John V. Barrow (Chairman)	Los Angeles	1940

Committee on Health and Public Instruction

Fred B. Clarke (Chairman)	Long Beach	1938
W. R. P. Clark	San Francisco	1939
Benjamin W. Black	Oakland	1940

Committee on History and Obituaries

Frank R. Makinson (Chairman)	Oakland	1938
J. Marion Read	San Francisco	1939
A. Elmer Belt	Los Angeles	1940

Secretary ex officio
Editor ex officio

Committee on Hospitals, Dispensaries and Clinics

George Dawson	Napa	1938
Daniel Crosby (Chairman)	Oakland	1939
Karl L. Schaupp	San Francisco	1940

Committee on Industrial Practice

Morton R. Gibbons (Chairman)	San Francisco	1938
Philip Stephens	Los Angeles	1939
Harry E. Zaiser	Orange	1940

Committee on Medical Defense

George G. Reinle (Chairman)	Oakland	1938
Fred R. De Lappe	Modesto	1939
John P. Nuttall	Santa Monica	1940

Committee on Medical Economics

John H. Graves (Chairman)	San Francisco	1938
William R. Molony, Sr.	Los Angeles	1939
Edward M. Pallette	Los Angeles	1940

Committee on Medical Education and Medical Institutions

B. O. Raulston	Los Angeles	1938
Loren R. Chandler (Chairman)	San Francisco	1939
John B. Doyle	Los Angeles	1940

Committee on Membership and Organization

E. Vincent Askey (Chairman)	Los Angeles	1938
Dewey R. Powell	Stockton	1939
G. Dan Delprat	San Francisco	1940

Secretary ex officio

Committee on Postgraduate Activities

F. E. Clough	San Bernardino	1938
F. F. Gundrum	Sacramento	1939
John C. Ruddock (Chairman)	Los Angeles	1940

Secretary ex officio

Committee on Publications

Ruggles A. Cushman	Talmage	1938
Oscar Reiss	Los Angeles	1939
Ralph Eusden (Chairman)	Los Angeles	1940

Secretary ex officio
Editor ex officio

Committee on Public Policy and Legislation

Junius B. Harris (Chairman)	Sacramento	1938
T. Henshaw Kelly	San Francisco	1939
E. T. Remmen	Glendale	1940

President ex officio
President-elect ex officio

Committee on Scientific Work

J. Homer Woolsey	Woodland	1938
F. M. Pottenger	Monrovia	1939
Lemuel P. Adams	Oakland	1940

Howard F. West, Secretary of Section on General Medicine, ex officio
Nelson J. Howard, Secretary of Section on General Surgery, ex officio
Frederick C. Warnshuis (Chairman), ex officio

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Charles A. Dukes, the secretary is Frederick C. Warnshuis. The director of the Department of Public Relations is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke.....Chair., Com. on Health and Public Instruction
Daniel Crosby.....Chair., Com. on Hospitals, Dispensaries, Clinics
Morton R. Gibbons.....Chair., Com. on Industrial Practice
E. Vincent Askey.....Chair., Com. on Membership and Organization
John H. Graves.....Chair., Com. on Medical Economics
Junius B. Harris.....Chair., Com. on Public Policy and Legislation
Charles A. Dukes.....Chair., Cancer Commission
John C. Ruddock.....Chair., Com. on Postgraduate Activities
Howard Morrow.....President of California Medical Association
William W. Roblee.....President-elect
Frederick C. Warnshuis.....Secretary-Treasurer

Communications for the Public Relations Department should be addressed to the Director, Frederick C. Warnshuis, M. D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Orville Meland (Sec'y for Southern Section)	Los Angeles	1938
A. Herman Zeiler	Los Angeles	1938
Gertrude Moore	Oakland	1938
Harold Brunn	San Francisco	1939
Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
Charles A. Dukes (Chairman)	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940

Communications for the Cancer Commission should be addressed to the secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

(Roster lists of officers of scientific section, component county societies, Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)



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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, Clarence A. DePuy, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society
President, Raymond Kilduff, 322½ Meyers Street, Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Selby H. Marks, Grabstein Bldg., Pittsburg.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
President, Henry A. Randel, Box 2308, Fresno.
Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Francis M. Stump, Crescent City.
Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Henry B. Graeser, 115 E. Fifth Street, Holtville.
Secretary, William A. Clarke, Holtville.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, Harry W. Lange, Hopkins Bldg., Bakersfield.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8 p.m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, George H. Kress, 945 Roosevelt Bldg., 727 W. 7th St., Los Angeles.
Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, W. Scott Polland, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Thomas P. Hill, Lakeport.
Secretary, Charles A. Craig, Lakeport.
Meeting, *On Call.*

Merced County Medical Society
President, E. M. Soderstrom, Merced.
Secretary, Fred O. Lien, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

*Deceased

Monterey County Medical Society
President, Curtis B. Gorham, 215 Franklin Street, Monterey.
Secretary, Harold R. Lusignan, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Walter Rapaport, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, G. Wendell Olson, 211 No. Pomona St., Fullerton.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. Ettrick Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, D. D. Roos, Corona.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Dave Dozier, California State Life Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, *L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Delbert B. Williams, 401 North Eighth Street, Colton.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, Bryant R. Simpson, 1205 Medico-Dental Building, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William C. Voorsanger, 490 Post St., San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, A. C. Boehmer, Box 306, Lodi.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Frederick R. Mugler, 1170 Marsh Street, San Luis Obispo.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

San Mateo County Medical Society
President, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, E. J. Lamb, 1515 State Street, Santa Barbara.
Secretary, J. Jerome Rupp, 16 E. Junipero Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, E. O. G. Schmitt, 608 Medico Dental Bldg., San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, Dean S. Woodard, Stoesser Bldg., Watsonville.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Mathew D. Pratt, Fall River Mills.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, J. B. McGuire, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Second Sunday.*

Solano County Medical Society
President, Ream S. Leachman, 727 Sonoma St., Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Alfred A. Thurlow, 505 B St., Santa Rosa.
Secretary, C. M. Carlson, 534 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Joseph L. Azevedo, Jr., 1024 "J" Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, E. R. Zumwalt, Tulare.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, Grundy C. Coffey, Bank of America Building, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Charles S. Roller, Woodland Clinic, Woodland.
Secretary, W. J. Blevins, Jr., Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society
President, Neal M. Loomis, Yuba City.
Secretary, Fred W. Didier, Wheatland.
Meeting, *Second Tuesday.*

(Roster lists continued on advertising page 6)

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COLEMAN A. BLOCK, M. D., *Secretary of Staff*



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E. S. KILGORE, M.D. Consultant in General Medicine
HAROLD HAND, M.D., Consultant in Gastro-Enterology
THOMAS G. INMAN, M.D., Consultant in Neuro-Psychiatry
JAY JACOBS, M.D., Dermatologist
CABOT BROWN, M.D., Consultant in Lung Diseases

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A. H. McNULTY, M.D.
ALVIN E. CERF, M.D.
SAMUEL A. GOLDMAN, M.D.
OSCAR F. NOLAN, M.D.

Radiology
LLOYD B. CROW, M.D.

Surgery
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House-Visiting Department
COLEMAN A. BLOCK, M.D.
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Pathology
DAVID A. WOOD, M.D., Director of Laboratory

Pediatrics
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WILFRED L. OLSEN, M.D., Assistant
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Anesthesia
HERMAN MARCUS, M.D., Chief
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E. C. Fabre-Rajotte, M.D., Chief
VICTOR D'ERCOLE, M.D., Assistant
C. B. COWAN, M.D., Associate

Obstetrics and Gynecology
CHESTER L. COOLEY, M.D.
M. A. FRANCOZ, M.D.
HANS VON GELDERN, M.D., Consultant

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

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Chairman, William LeRoy Garth, Medico-Dental Bldg., 233 A Street, San Diego.
Secretary, John G. Dunlop, 111 No. Normandie Avenue, Los Angeles.

Dermatology and Syphilology

Chairman, Stanley O. Chambers, 826 Roosevelt Building, 727 West Seventh Street, Los Angeles.
Vice-Chairman, Arne E. Ingels, 490 Post Street, San Francisco.
Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

Eye, Ear, Nose and Throat

Chairman, Frank Baxter, 1624 Franklin Street, Oakland.
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Chairman, Edwin L. Bruck, 384 Post Street, San Francisco.
Secretary, Howard F. West, 602 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

General Surgery

Chairman, Harlan Shoemaker, 1014 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Nelson J. Howard, 2814 Lyon Street, San Francisco.
Assistant Secretary, Ray B. McCarty, 3616 Main Street, Riverside

Industrial Medicine and Surgery

Chairman, Frederic C. Bost, 384 Post Street, San Francisco.
Vice-Chairman, Harvey G. McNeil, 523 West Sixth Street, Los Angeles.
Secretary, George H. Sanderson, 242 North Sutter Street, Stockton.

Neuropsychiatry

Chairman, Fred O. Butler, Sonoma State Hospital, Eldridge.
Secretary, John B. Doyle, 1930 Wilshire Boulevard, Los Angeles.

Obstetrics and Gynecology

Chairman, R. Glenn Craig, Medico-Dental Building, 490 Post Street, San Francisco.
Vice-Chairman, George W. Coon, 3770 Twelfth Street, Riverside.
Secretary, John N. Ewer, 411 Thirtieth Street, Oakland.

Pathology and Bacteriology

Chairman, Gertrude Moore, 2404 Broadway, Oakland.
Secretary, George D. Maner, 657 South Westlake Boulevard, Los Angeles.
Assistant Secretary, Paul H. Guttman, 1127 Eleventh Street, Sacramento.

Pediatrics

Chairman, E. E. Moody, 3780 Wilshire Boulevard, Los Angeles.
Secretary, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Assistant Secretary, W. W. Belford, 601 Medico-Dental Building, San Diego.

Radiology

Chairman, John D. Lawson, 1306 California State Life Building, Sacramento.
Secretary, Karl M. Bonoff, 1930 Wilshire Boulevard, Los Angeles.

Urology

Chairman, Lloyd E. Kindall, 400 Twenty-ninth Street, Oakland.
Secretary, Carl F. Rusche, 905 Taft Building, 1680 North Vine Street, Hollywood.

Delegates and Alternates to the American Medical Association

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C. A. Dukes, Oakland	(1937-1938)	Edward N. Ewer, Oakland
Edward M. Pallette, Los Angeles	(1937-1938)	W. H. Kiger, Los Angeles
Robert A. Peers, Colfax	(1937-1938)	F. F. Gundrum, Sacramento
William R. Molony, Sr., Los Angeles	(1937-1938)	John C. Ruddock, Los Angeles
Elbridge Best, San Francisco	(1938-1939)	Robert S. Stone, San Francisco
Lyell C. Kinney, San Diego	(1938-1939)	Bon. O. Adams, Riverside
J. P. Nuttall, Los Angeles	(1938-1939)	F. M. Pottenger, Los Angeles

Special Committees

Committee on Animal Experimentation

Philip Gilman, Chairman
Charles A. Dukes — Loren R. Chandler

Committee on Maternal Welfare

T. Henshaw Kelly — San Francisco
Lyle G. McNeile — Los Angeles
Ralph J. Thompson — Los Angeles
T. Floyd Bell — Oakland
Hans F. Schluter — Sacramento

Committee on Golden Gate International Exposition

T. Henshaw Kelly, Chairman
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Los Angeles
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Edward M. Pallette, Chairman (for Southern California), Los Angeles
Junius B. Harris, Chairman (for Remainder of State), Sacramento

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State Auxiliary Officers

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President-Elect, Mrs. Clifford A. Wright, 454 So. Irving Boulevard, Los Angeles.
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Second Vice-President, Mrs. Elliott G. Colby, 2457 Willow Street, San Diego.
Recording Secretary, Mrs. Harry E. Henderson, 1600 Orange Road, Santa Barbara.
Corresponding Secretary, Mrs. Charles C. Hall, 207 Estates Drive, Piedmont.
Treasurer, Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael.

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Butte County—Mrs. J. W. White, 314 W. Legion Avenue, Chico.
Fresno County—President, Mrs. A. E. Anderson, 1035 Cambridge Avenue, Fresno.
Kern County—President, Mrs. Jack Nicholson, 1821 Maple Street, Bakersfield.
Lassen-Plumas-Modoc County — President, Mrs. G. R. Fortson, 912 Lassen St., Susanville.
Los Angeles County—President, Mrs. Eliot Alden, 2008 North Serreno, Los Angeles.
Marin County—President, Mrs. Thomas Gocher, 201 Mt. View Avenue, San Rafael.
Monterey County—President, Mrs. Laurence M. Knox, Box 385, Carmel-by-the-Sea.
Orange County—President, Mrs. G. Wendell Olson, 219 Buena Vista Drive, Fullerton.
Riverside County — President, Mrs. T. A. Card, 4592 Aurora Drive, Riverside.
Sacramento County—President, Mrs. W. J. Van Den Berg, 1316 Forty-sixth Street, Sacramento.
San Diego County—President, Mrs. Elliott G. Colby, 2457 Willow Street, San Diego.
San Francisco County—President, Mrs. Hans Barkan, 3653 Jackson Street, San Francisco.
San Joaquin County—President, Mrs. F. G. Maggs, 228 Fulton Street, Stockton.
San Luis Obispo County—President, Mrs. Jens Larson, 2000 Spring St., Paso Robles.
Santa Barbara County—President, Mrs. Clarence Roome, 2747 Questa Road, Santa Barbara.
Santa Clara County—President, Mrs. Henry Milo, Mountain View.
Santa Cruz County—Mrs. Alfred L. Phillips, 220 Escalona Drive, Santa Cruz.
Tulare County—President, Mrs. J. C. McClure, Box 36, Lindsay.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—State Office Building, McAllister and Larkin Streets. UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building, San Francisco.

California Northern District Medical Society

President—Percy B. Gallegos, 242 North Sutter Street, Stockton.
Secretary—Dave F. Dozier, 926 J Street, Sacramento.

Board of Medical Examiners of the State of California

San Francisco, Rm. 512, 450 McAllister St.
Los Angeles, 906 State Building.
Sacramento, 420 State Office Building.
President, William R. Molony, Sr., Los Angeles.
Secretary, C. B. Pinkham, Room 512, 450 McAllister Street, San Francisco.

Southern California Medical Association

President, Franklin R. Nuzum, Cottage Hospital, Santa Barbara.
Secretary, Robert W. Langley, 1002 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

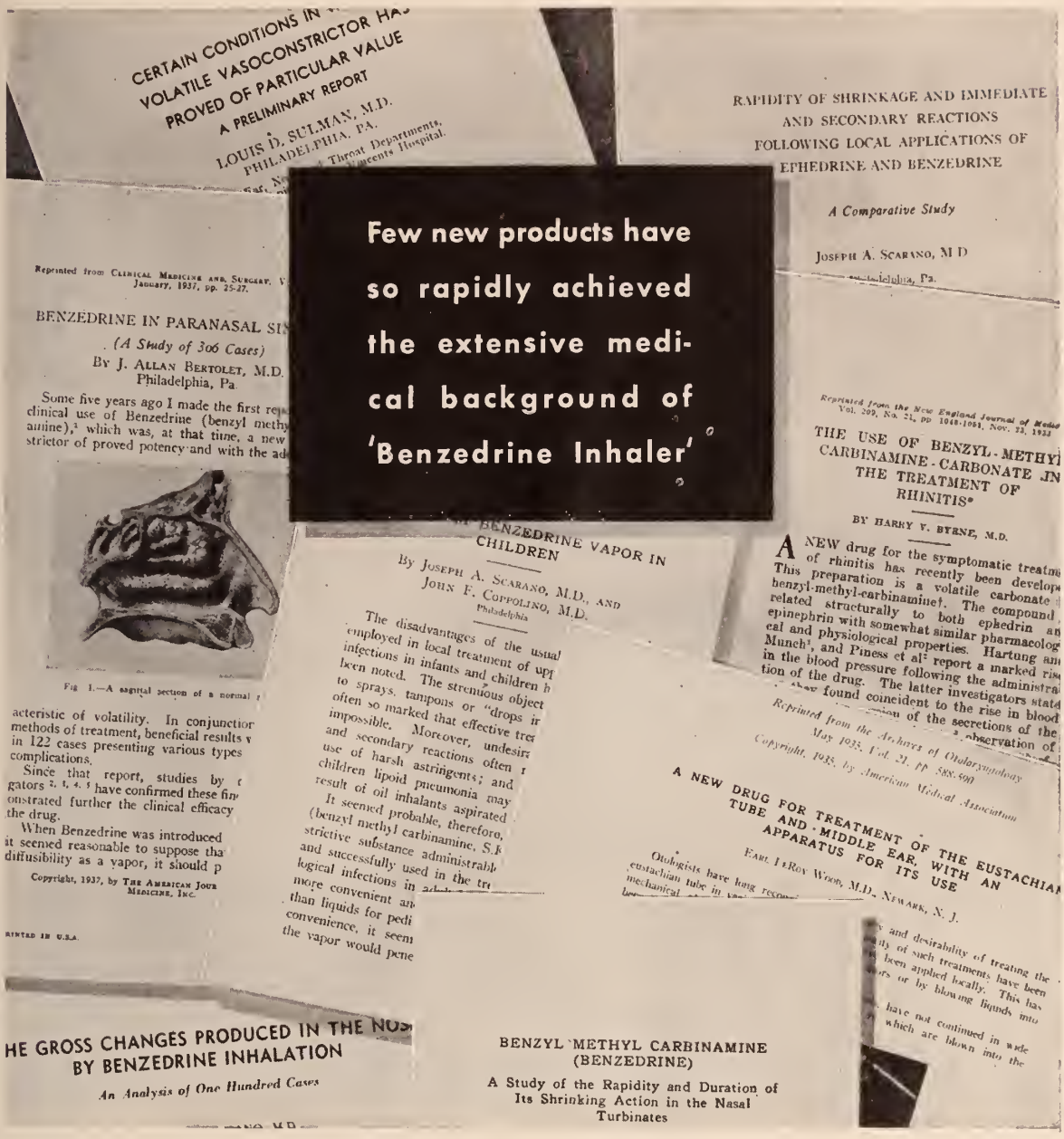
The Public Health League of California

Executive Secretary, Ben H. Read. San Francisco office, 450 Sutter Street. Los Angeles office, Room 563, 1151 South Broadway.

Better Health Foundation

President, Reginald Knight Smith,* 490 Post Street, San Francisco.
Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco.
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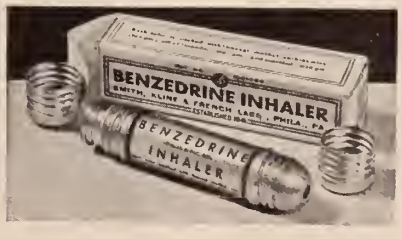
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Mental Effects of "Benzedrine Sulfate."—Molitch and Sullivan (Am. J. Orthopsych., 7:519, October, 1937) report on the mental effects of "Benzedrine Sulfate" (benzyl methyl carbinamine sulfate, S. K. F.).

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We do not know what lies next in the evolution of public health. Possibly it may be a comprehensive plan whereby all members of society may receive a more equitable distribution of the benefits of medical care, especially among the indigent and low income groups. We do know, however, that the vast majority of our preventable ills are conquerable by the application of such knowledge as we already have. It is not meant to imply that the successive waves of public health evolution have supplanted those preceding, on the contrary, all phases of public health knowledge and practice are necessary in a complete and well-balanced health program.—The Health Officer.

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This new edition is really a new book, entirely reset, printed from new type. Most of the illustrations have been remade and the book has been enlarged to include the Child as well as the Infant. An especially strong chapter has been added on Behavior Problems by the well-known authority, Dr. Olga Bridgman. Among the newer things included in this edition are: Diarrhea, Nutrition, Prematurity, Poliomyelitis, Behavior, Allergy, Syphilis, Tuberculosis, New Therapeutic Agents, Office "Feeding Service," and Well-Baby Clinics. This is essentially a HOW book—telling HOW to do this, that, or the other thing in treating the sick infant and child.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

A History of Women in Medicine. From the Earliest Times to the Beginning of the Nineteenth Century. By Kate Campbell Hurd-Mead, M.D. Cloth. Pp. 569, illustrated. Price, $6. Haddam, Connecticut: The Haddam Press, 1938.

The Physician's Business. Practical and Economic Aspects of Medicine. By George D. Wolf, M.D., Attending Otolaryngologist, Sydenham Hospital, New York City; Attending Laryngologist, Riverside Hospital, New York City; Fellow, New York Academy of Medicine; Fellow, American Medical Association. Foreword by Harold Rypins, A.B. M.D., F.A.C.P. Cloth. Pp. 384, with 57 illustrations in the text. Price, $5. Philadelphia: J. B. Lippincott Company, 1938.

Malnutrition the Medical Octopus. By John Preston Sutherland, M.D., Sc.D. (Hon.), Dean Emeritus, twenty-one years Professor of Anatomy, twenty years Professor of Theory and Practice, in Boston University School of Medicine; fourteen years Editor of the *New England Medical Gazette;* Past President of the International Homeopathic Congress; since 1923 member of the Editorial Board of the *New England Journal of Medicine;* member of the Massachusetts Medical Society. Cloth. Pp. 368. Price, $3. Boston: Meador Publishing Company, 1937.

Eighth International Congress of Military Medicine and Pharmacy and Meetings of the Permanent Committee, Brussels, Belgium, June 27 to July 3, 1935. Report of Captain William Seaman Bainbridge, M.C.-F., U.S.N.R., Retired, member of the Permanent Committee for the Delegation of the United States of America. Cloth. Pp. 114. Washington: United States Government Printing Office, 1937.

Annual Report of the Surgeon-General of the Public Health Service of the United States. For the Fiscal Year 1937. Paper. Pp. 164. Price, 60 cents. Washington: United States Government Printing Office, 1937.

Physicians' Vitamin Reference Book. Presenting to the Clinician a Useful Compendium of the Latest Facts About Vitamins. By the Medical Division, Professional Service Department of E. R. Squibb & Sons. Cloth. Pp. 126. New York: E. R. Squibb & Sons, 1938.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 232)

board of drugless examiners, and a board of registration of religious practitioners." The title of the Act is "To regulate the practice of medicine, surgery, and other systems or modes of treating the sick or afflicted," etc. Thus it is evident that *all who come under it are to do the same things.* But we find that those in the first class must comply with all present requirements and take an examination; those in the second class need have no preliminary education and but two years' study in some school of drugless healing, and in addition the law licenses all osteopaths, chiropractors, naturopaths, and any other breed of drugless healer—in fact, anyone who has joined the "federation of liberal physicians, surgeons, and healers" before July 1, 1913! In the third class, practically no requirements are demanded.

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(Continued on Next Page)



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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

a license in this State under our present moderate requirements. It is also to be noted that our present requirements are much lower than those of several other states.

There seems to be a mad desire on the part of a large number of people to "take a whack" at the sick or afflicted and perhaps it would be a good thing to abolish the law entirely and let everyone treat anyone.

* * *

Medical Education in Europe.—The Carnegie Foundation's report upon Medical Education in the United States and Canada created much excitement, from east to west, because of the disclosures it made concerning the evil conditions of the many proprietary schools extant. . . .

Before beginning the discussion of medical education proper, the book contains a most important chapter—perhaps *the* most important chapter—on the basis of medical education, which is the preliminary training gotten in the secondary schools. . . . Mr. Flexner very properly treats the subject at the length which its importance merits; and in the same way, in a succeeding chapter, he emphasizes the need of the study of the basic sciences, physics, chemistry, and biology, "for the medical sciences are experimental, not merely descriptive, and while even in their descriptive form they cannot be understood without a knowledge of the basic sciences, intelligent experimental study is out of the question to a student who lacks practical skill, brought over from the basic sciences."

* * *

The Educational Value of Moving Pictures.—Since 1910 it has not been an uncommon event at European scientific congresses to witness a display of moving pictures illustrative of physiological phenomena and the life of microscopic human parasites. In this country, with the exception of a few demonstrations made in the East, little attention has been paid to the subject by universities and medical societies.

T. W. Weisenburg of Philadelphia (*Journal of the American Medical Association,* December 28, 1912), in an article entitled "Moving Picture Illustrations in Medicine," draws the attention of the profession to this advance of contemporary science as applied to medicine.

There is no doubt that in the future motion pictures are destined to play an important rôle in the education of the medical student, just as they are today playing a tremendous rôle in the education of the public. The so-called "Nickelodeon," which as a result of the increase in the cost of living may soon be rechristened "Dimeodeon," has certainly done a great deal in the teaching of history, of geography, or art, many of the lessons being easily swallowed and well assimilated in this gelatin-film coated form, whereas these same lessons might not have been at all digested if presented even on a series of so-called lantern slides.

The Edison Company has recently sent out a prospectus announcing the production of a small inexpensive moving picture machine, with small-sized films, and recommended its adoption by universities and medical societies.

From an Article on "Chinese Medicine in America" by Charles Kirkland, M. D., Wei-hsien, China.—Conditions in China as a result of, or in spite of, the native practice of medicine, are bad enough; but it appears that certain wily Celestials are actually trying to introduce their system of medicine into America. It is hard for one not on the ground to tell just how far this propaganda has advanced, but to judge by pamphlets and newspaper articles, it has gained quite a foothold, at least on the Pacific Coast. At any rate, it seems time that the public should know something of the truth about the native pharmacopeia and practice of medicine in China. The writer has no intention of being drawn into a controversy on this subject. A certain wise old medical man (named Oliver Wendell Holmes) once said: "Controversy equalizes fools and wise men, and the fools know it." This adage largely explains why medical men as a class are so slow to enter the lists and appeal to the public prints in defense of what they know to be the truth. It is only in cases of glaring misstatement, with

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plausible promises incapable of fulfillment, that the temptation to tell a little truth, if only to relieve the monotony of lies on the subject, becomes irresistible.

From an Article on "Sarcoma of the Uterus" by Emmet Rixford, M. D., San Francisco.—Sarcoma of the womb is commonly regarded as a comparatively rare tumor and as a consequence has received very little attention from clinicians until within recent years. While cases of "recurrent fibroids" had been observed and recorded, and which were doubtless sarcomatous, the first case to be designated sarcoma of the womb was reported by Carl Mayer in 1860, a polypoid sarcoma of the uterine mucous membrane, of which the diagnosis was verified by Virchow.

From an Article on "Some Observations on Symptoms and Treatment of Suppurative Appendicitis" by Robert T. Legge, M. D., McCloud, California.—Subject accepted for a paper before this society has been so often written about and discussed in the past two decades, that I venture to present it with an apology for its staleness.

When we consider, however, that more than one-half of our laparotomies are performed for appendicitis, I think you will appreciate that it behooves us to keep well in touch with the observations and experiences of our leading surgical clinics.

In country hospitals as well as in city charitable institutions the surgeon encounters more suppurative appendicitis than he does in private practice; the reason being, of course, due to delays, improper diagnosis, procrastination, and the so-called medical treatment of cases.

Conclusions:

1. Plea for early operations, no procrastination permissible.
2. In profound septic cases, incision and drainage will suffice as operative means.
3. Proctoclysis only to be used in postoperative treatment.
4. Ideal postoperative treatment is Fowler's position, padlock on mouth, and Murphy's proctoclysis.
5. Temperature is not a reliable guide.

Membership of California's County Societies.—For the years 1906 and 1912.

	1906	*1912*
Alameda	121	216
Butte	14	22
Contra Costa	21	20
Fresno	56	63
Humboldt	35	33
Kern	12	22
Kings	6	
Los Angeles	348	606
Marin	14	19
Mendocino	12	8
Merced		10
Monterey	23	20
Napa	18	19
Orange	24	31
Placer	20	25
Riverside	21	30
Sacramento	55	70
San Benito	9	3
San Bernardino	35	37
San Diego	39	85
San Francisco	540	554
San Joaquin	41	69
San Luis Obispo	11	14
San Mateo	7	16
Santa Barbara	28	21
Santa Clara	88	83
Santa Cruz	21	26
Shasta	30	30
Solano	19	8
Sonoma	48	47
Tehama	9	8
Tulare		26
Tuolumne	13	8
Ventura	12	10
Yuba-Sutter	10	11
Yolo	17	17
	1,777	2,278

(Continued on Next Page)



TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Sacramento County Society Report.—At a meeting of the Sacramento Society for Medical Improvement, held on January 21, the following officers were elected for the year 1913: G. L. Stevenson, president; F. E. Shaw, secretary; G. L. Stevenson, F. E. Shaw, H. L. Nichols, G. A. White, and W. A. Briggs, directors; F. F. Gundrum, two years; G. C. Simmons, one year; and A. M. Henderson, one year.

State Medical Association: Council's Report for 1912-1913.—All of our accounts, vouchers, canceled checks, etc., since May, 1905, are intact and in the safe deposit; they have all been audited each year by certified public accountants who are responsible for the accuracy of their audit. In this statement we have not gone into many burdensome details, but it may be said that no matter of expense has been undertaken without consideration and sanction by the Council, and that not a dollar of money has been paid out until after the charge has been investigated and approved in writing by the auditing committee of the Council.

Year	Receipts	Expenses	Gain	Loss
1905	$ 8,791.34	$ 8,524.40	$ 266.94	
1906	10,634.99	11,085.55		$ 450.56
1907	11,745.23	11,311.05	434.18	
1908	10,238.94	10,669.68		430.74
1909	12,670.01	12,084.06	585.95	
1910	14,147.27	13,919.13	228.14	
1911	15,719.03	14,241.13	1,477.90	
1912	17,241.19	17,522.91		281.72
Totals	$101,188.00	$99,357.91	$2,993.11	$1,163.02
Net gain eight years				$1,830.09
Plus loans repaid, 1910				2,000.00
				$3,830.09

(Signed): C. G. Kenyon,
Chairman of the Council.
Philip Mills Jones,
Secretary.

From Some News Notes from Newspapers:

The German Hospital, San Francisco, has been sued for $25,000 because of the death of a boy from rabies.

Oakland supervisors—or rather, Alameda county supervisors—have allotted one million dollars for the new county infirmary.

San Diego County Medical Society had its annual dinner on January 16, and the older resident physicians recited their hard-luck stories of early days.

The Good Samaritan Association has purchased the Columbia Hospital at Los Angeles, and thus enlarged its usefulness materially. It is an Episcopalian institution.

On January 31 there were 862 patients in the Los Angeles County Hospital, and it is stated that within a year the new hospital building will be inadequate to accommodate the patients that will have to be cared for.

The bill requiring a medical certificate before a marriage license is issued is creating a good deal of discussion at Sacramento, and the newspapers comment upon the frankness of the language used; it would be well if the papers would be as frank.

An outrageous suit has been filed against Dr. E. R. Bryant, San Francisco, because he did not respond to a call to attend a former patient when he, himself, was ill. This would look like plain blackmail and, of course, he will win the suit if it is ever tried.

The physician can perhaps make his greatest contribution to a child health problem when the public is educated to the need of having children examined regularly once, or better twice, a year, even in the absence of symptoms of disease. Many mothers bring their babies to the physician regularly for inspection and health advice, and school children receive at least a certain amount of attention. But in the ages between, very little is done, with the result that large numbers of children enter school at the age of six with various defects, many far advanced. The public does more in this kind of prevention dentally than medically, which indicates what can be accomplished by the proper sort of education.

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VITAMIN A
2000 U. S. P. Units added to each Tall Can (13 Fl. Oz.)



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400 U. S. P. Units added to each Tall Can (13 Fl. Oz.)

[1] *From Journal AMA, 108:206 (Jan. 16, 1937):*

REQUIREMENTS AND ALLOWABLE CLAIMS FOR VITAMIN D MILK:

To be acceptable to the Council on Foods, bottle caps and labels for Vitamin D milks must declare unitage of the vitamin D in terms of U. S. P. units and the source of the vitamin D, unless local government regulations prohibit such declarations.

For all milks containing a minimum of 135 units, an enhanced nutritive value, especially for growing children, may be claimed; it is also permissible to state that these milks usually will prevent clinical rickets when they are fed to normal infants in customary quantities.

For milk with only 135 units to the quart there shall be no claim or intimation that an adequate amount of vitamin D is being supplied to infants. When the milk contains as much as 400 units to the quart, the claim may be made that the amount of vitamin D is greater than that usually required for the prevention of rickets in normal infants and thus that a margin of safety is offered when customary amounts of milk are taken.

The foregoing statements which have been made concerning vitamin D in fresh milk apply equally to evaporated milk after it has been diluted with an equal volume of water.

[2] Special Morning Milk contains 496 U.S.P. units of Vitamin D per reconstituted quart (16 fluid ounces of milk and 16 fluid ounces of water). Thus Special Morning Milk has an additional margin over "a margin of safety" of 96 units of Vitamin D per reconstituted quart or approximately 24%.

- SPECIAL MORNING MILK IS THE ONLY EVAPORATED MILK PRODUCED IN CALIFORNIA USING COD LIVER OIL CONCENTRATE AS ITS SOURCE OF VITAMIN D.
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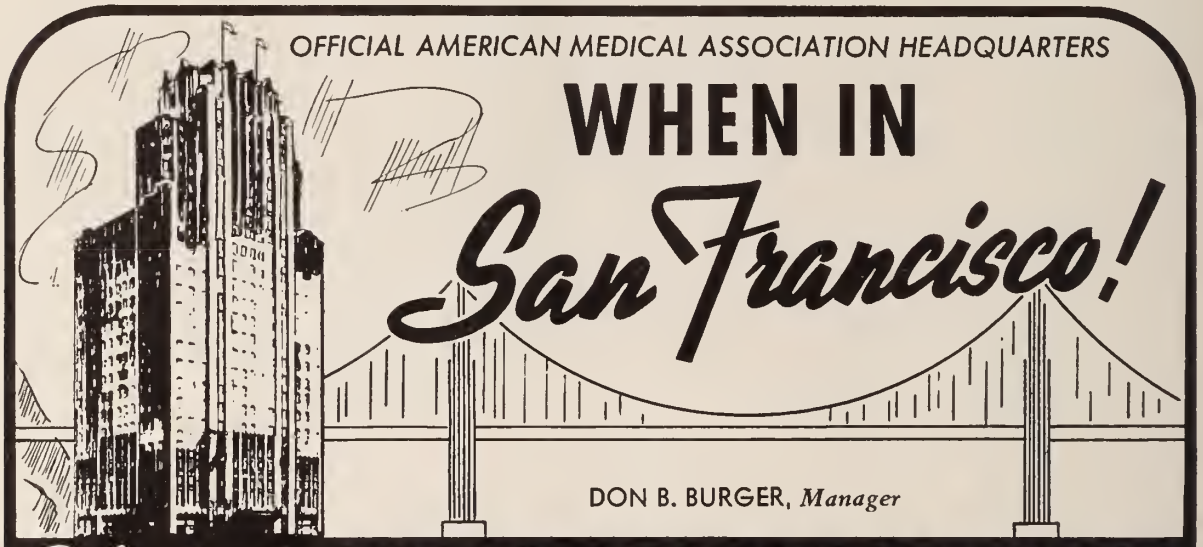
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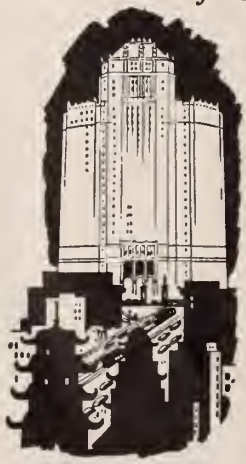
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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 232)

practiced medicine while holding only the chiropractor's license. The charge was sworn to by Inspector Ronan of the State Medical Board. . . . The state inspector charges that the chiropractor prescribed medicine while not possessing a license. . . . It is claimed by the defendant chiropractor that the 'medicine' the State charges he prescribed was only a substance containing vitamins." (Riverside *News*, January 20, 1938.)

"The House Immigration Committee yesterday approved a bill to cancel deportation orders issued against Dr. Filiberto A. Bonaventura, a Santa Rosa, California, physician. The orders had been issued against Bonaventura, a native of Italy, as the result of a narcotic law conviction in 1932 in Ohio. The offense, however, was declared to have occurred in 1930, while the Immigration Act under which deportation orders were issued was passed on February 18, 1931." (Associated Press dispatch, dated Washington, January 26, 1938, and printed in the Sacramento *Bee* on the same date.)

"Dr. Allen F. Gillihan, county health officer, on Monday tendered his resignation to the board of supervisors, because of ill health. The resignation, which asked that the officer be relieved of his duties on March 1, was accepted with the proviso that Doctor Gillihan remain at his post until a successor could be found. Members of the board expressed regret that the physician's health compelled him to give up the supervision of the department, and gave high praise for his conduct of his office, declaring that the county department was one of the most efficient in California. . . ." (San Luis Obispo *Telegram*, January 18, 1938.)

"News dispatches from Tampa say the Florida State Board of Medical Examiners refused to consider the application to practice medicine of Dr. William Loesner of Chicago, on the ground he was the physician who performed the face lifting and identification mark removing operations on Charles Dillinger. The board is right, and should receive the praise of physicians and laymen everywhere. If such acts do not, as the board argued, violate 'the ethics of the medical profession,' what could? The physician debases his profession who becomes the active aid of a Dillinger, assisting the enemies of society. Such a physician should be denied the right to practice medicine in Florida or any other state." (Editorial, Sacramento Bee, January 21, 1938.)

"A surprise move by the prosecution for dismissal of a felony charge against 'Dr.' Richard J. Howard, Hacienda rancher, who was scheduled to go to trial in the Sonoma County Superior Court next Monday, and William Patrick Devine, twenty-six, former employee of Howard, was granted on Friday by Judge Donald Geary. Grounds of insufficient evidence of conspiracy was given by Deputy District Attorney Les Manker for the move. Prospective jurors had already been summoned. Howard is now awaiting trial in the Healdsburg justice court on misdemeanor charges of violating the State Medical Practice Act. The conspiracy charge was based on a similar allegation, accusing Howard and Devine of conspiring to treat one Thomas White for cancer." (Petaluma *Argus-Courier*, January 15, 1938.) (Previous entries, December, 1929; June, 1932.)

"Charges four years old against Dr. M. M. Doria of having attempted to shoot R. I. Rasmussen and of having stabbed Mrs. Nettie Rasmussen, parents of Olive Rasmussen, eighteen, whom he afterward married, were dismissed in municipal court today at request of the Rasmussens. District Attorney Thomas Whelan agreed to the motion for dismissal. One complaint, drawn up in 1933, when the alleged acts were committed, listed Rasmussen as complaining that Doria drew a pistol and fired, the

(Continued on Next Page)



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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

bullet striking the floor, when the parents objected to their daughter accompanying the elderly physician December 21 of that year. . . . The other complaint charged that on December 26, 1933, when Mrs. Rasmussen, accompanied by Olive, called upon Doria in his office in the Watts building, to remonstrate with him, the older woman was stabbed in the shoulder with a small surgeon's knife. Doria fled across the border subsequently and avoided arrest, Whelan said. On April 7, 1934, the physician and Miss Rasmussen were married. . . ." (San Diego *Tribune*, January 7, 1938.) (Former entries, February and July, 1934.)

"An initiative measure, aimed at revolutionizing the medical profession, has just been granted a title by the office of Attorney-General U. S. Webb at the request of M. James McGranaghan of San Francisco, who is seeking to obtain enough signatures to place the measure on the ballot at the general election next November 8. The measure would provide penalties for unnecessary major operations, require prescriptions to be written in English, and 'create a conclusive presumption of unskillfulness if a surgeon has less than five hundred hours of surgical training or has participated in less than fifty major operations.' The measure would also re-

(Continued on Page 22)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 20)

define the practice of medicine." (San Fernando *Sun*, January 4, 1938.)

"An unidentified San Diego mother, whose name is being withheld by authorities, was near death in Quintard Hospital today, and Dr. E. Blanche Ramer, fifty-seven, was charged with performing an illegal operation upon her. According to Thomas Frost, Investigator for the District Attorney, hospital authorities hold 'little chance' for recovery of the woman, mother of two children. . . . Doctor Ramer, her attorney said, was to be arraigned in municipal court today. She was arrested on a warrant charging her with performing the alleged illegal operation. . . . Her license was revoked several months ago by the State Board of Medical Examiners, but since that time her attorney has obtained a temporary restraining order blocking the revocation. . . . Doctor Ramer denied any knowledge of the charges against her, according to Frost." (San Diego *Sun*, January 12, 1938.)

"Murder was charged yesterday against Dr. Blanche Ramer, San Diego physician, following the death of Mrs. Monte Beck, thirty-seven, victim of an alleged illegal operation. . . . Mrs. Beck, mother of two children, and employed as a department store saleswoman, is alleged to have submitted to the operation last December 4 and died yesterday at Quintard Hospital, where she was taken on December 20." (San Diego *Union*, January 15, 1938.)

"With the knowledge that truth is often much stranger than fiction, Warner Bros. are going to the daily newspapers for material for several pictures which are apt to prove veritable sensations as well as accomplish a lot of good. They are planning to expose, through the powerful medium of motion pictures, different racketeers who have

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fastened their tentacles on the general public. Probably foremost among these human vultures are quack doctors. To insure truth in every phase of the production, the cooperation of Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* has been enlisted. Another group which will be exposed is the world-wide one that deals in the insidious drug traffic. And a third group are the shyster lawyers, who render it difficult for honest district attorneys to enforce the law against criminal offenders." (San Jose *Mercury-Herald,* January 16, 1938.)

"Negligent use of the drug dinitrophenol, which, she asserts, caused her to go blind, is charged in the petition of a suit for $28,000 damages filed late yesterday in the Superior Court by Helen M. Reed against a physician, a druggist, and others." (Los Angeles *Times,* January 14, 1938.)

"At a cost of $350,000, a new Hahnemann hospital will be erected this year, according to plans being perfected yesterday by a committee headed by Marshal Hale. The hospital, to contain eighty beds and provision for expansion, will be located on the California and Maple streets site occupied by the old Hahnemann Hospital for twenty-five years. The old building was razed in 1930. The new hospital, sponsored by the Homeopathic Foundation of California, will be open to all physicians. . . . John L. McNab and John M. Grant, with Hale, make up the Executive Committee. . . . A campaign committee, including prominent professional and business men, is aiding the Executive Committee. . . . Dr. James W. Ward of San Francisco, regarded as the dean of the homeopathic profession, has given his extensive library to the Homeopathic Foundation and it will be housed in the new auditorium-library of the new hospital, the committee announced." (San Francisco *Examiner,* January 15, 1938.)

"Selection of a jury was begun today in Superior Judge Frank M. Smith's court, to try Dr. W. B. Humphrey, a physician, and Louis Feinstein, an attorney, on charges growing out of an investigation last year by a jury into the operation of a so-called 'fake accident' ring. . . ." (Los Angeles *Herald and Express,* January 24, 1938.)

"Oakland's beauty shop insurance fraud cases ended officially yesterday when Superior Judge Lincoln S. Church sentenced the two defendants, one of whom leaped up and protested bitterly. He was Emil Grossman, Oakland attorney, whom the court styled the 'arch conspirator' in the plot, and who was committed to San Quentin for a term of one to ten years on charges of fraud, conspiracy, and grand theft. 'I should get the same consideration as Judge George Hickman,' Grossman shouted. (Hickman was convicted of extortion from café owners in a license-fixing case, served about a year in jail and is now at liberty pending an appeal.) 'His crime was worse than mine, but you are sending me to San Quentin.' Judge Church ignored the outburst. The second defendant, Dr. Louis Kameny of Oakland, was sentenced to a year in jail, with three years' probation. Both men were accused of plotting with Mrs. Adrienne Udstone to commit an insurance fraud. The woman, who was acquitted, supposedly was burned in a beauty shop. The plan was to have the shop operator take out a policy for protection against such accidents, then collect." (San Francisco *Examiner,* January 21, 1938.)

Henry H. Rogers is reported to have pleaded guilty to a violation of the Business and Professions Code in Los Angeles and to have been sentenced to 180 days in the city jail, sentence suspended on condition he leave the State within forty-eight hours and not return for two years.

Investigation reports show Samuel D. Collins was recently denied probation, after being found guilty by a jury of violation of the Business and Professions Code, where-

(Continued on Next Page)

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upon he was sentenced to serve ninety days in the city jail, forty-five days being suspended, and he was committed.

Records show that on December 20 Harry T. Bottrell pleaded guilty in Los Angeles on a charge of violation of the Medical Practice Act and on December 20 was sentenced to serve 180 days in the city jail, suspended two years on condition he leave the United States within thirty days.

The Los Angeles *Daily Journal*, Friday, December 31, 1937, related that the Appellate Division of the Los Angeles Superior Court ruled that "Opticians employed by the Kindy Optical Company are not permitted to adjust glasses on the person for whom they have been prescribed."

The danger of fumigating with methyl bromid was mentioned in a December, 1937, report of the Department of Industrial Relations to the Governor's Council, in the following language: "Recently in California two men were fumigating a house and as the result of the exposure to this fumigant one man died and the other man, although he was made very sick, appears to be all right at this time."

Individual Responsibility for Health.—Public health provides a service to the community. In the early stages of its administration as a governmental unit, public health was concerned chiefly with environmental factors that had to do with the promotion of community health. Sewage disposal, water and milk supplies, fly and mosquito control and general sanitation were the supporting pillars in every community health program. They still uphold most of the structure, but during recent years more widespread and intensive activities that have to do with the individual citizen have been developed. Of these, immunization against smallpox, diphtheria, and typhoid fever has been, and still is, most important. Many other personal attributes provided through services to the individual have been added to the general health program as practiced in the average community. Among them are prenatal service, child care, dental hygiene, pneumonia control, educational and other services that require application of recognized methods of procedure at the hands of trained workers.

While this type of activity seems to be in the form of grants to the individual it is actually the provision of a service that helps people to do things for themselves. It requires action upon the part of the individual and demands continued activity in order to achieve results. Of this Surgeon-General Parran of the United States Public Health Service has said:

"Public health today consists of helping people to do things for themselves. The pregnant woman should seek medical care early. The mother must know the essentials of proper feeding and care of her baby and avail herself of the protective inoculations against such diseases as diphtheria and smallpox. The school child must be taught good health habits. The pneumonia patient must call the doctor early in order that serum may be of value. Regular examinations, including x-rays when necessary, make it possible for tuberculosis to be discovered in its curable stages. The only hope of cure from cancer is similarly citizen interest, knowledge, and participation in finding the disease and securing proper treatment."

The natural tendency among scientists to carry any new theory or practice to extremes has not been discouraged by the manufacturers of biological products, so that the virtues of immunization in many lines have been greatly overrated, under pressure of commercial interests. While this wave is by no means spent, it is believed that its crest has passed, and that immunization will in the future be regarded more in the light of its true rather than inflated values.—The Health Officer.



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Our laboratory is modern and complete and is manned by competent university trained chemists. No expense is spared to make research complete. No preparations are ever offered the laity.

Such is the background of Smith-Dorsey products.

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FOUNDED 1908

Dentistry in Public Health.—It has long been recognized by the medical profession and health officials that the dentist is playing a very important part in public health work. When it is known that many systemic diseases can be traced directly to mouth conditions, it then becomes imperative for a community to become more mouth conscious, and it is with that thought in mind that the Bureau of Dental Hygiene of the State Department of Health is functioning in coöperation with the Health Commissioners, school officials, parent-teachers, civic clubs, and all other organizations interested in health in presenting public health to the people from a dental standpoint. It being known that the mouth, affording an ideal culture media for bacteria, has practically every known bacteria present at all times, and if the mouth is not kept as clean as is humanly possible the danger of carrying infection throughout the system by means of the blood stream is greatly enhanced.

The dentist should play a very important part in the teaching of the children and parents the importance of preserving and retaining the deciduous or baby teeth until time for their natural loss. Many malformations in later life can be traced to the too early loss of the deciduous teeth. A child cannot expect to grow into strong healthy manhood or womanhood without proper nutrition and care and the nutrition cannot be properly attained without a full complement of teeth, since the first steps of digestion begin in the mouth. If there is a loss of one of the members of mastication, either deciduous or permanent, one is quite naturally throwing more work upon the organs of the body to attain the height of digestion. It is appalling to know in our work, from the State Department of Health, that dental conditions lead the field in defects of children in all communities and here the dentist can play a very important part in getting the proper knowledge to the parents of these children as to the importance of retaining those teeth.

In our work of general surveys we find that much neglect is noted and not in all instances due to lack of funds, but in a great many cases the feeling is to extract the tooth and finally replace with false teeth. Here, also, the dentist can be honest with his patient and tell them that no restoration is ever so good as the natural tooth.

Purchasing Milk Intelligently.—Every morning thirty million bottles of milk are left on the doorsteps of America. Practically every citizen is a purchaser and consumer of the products of the great milk industry, and all should know a few of the essentials to be taken into consideration when selecting a source of supply for home consumption. These are purity, nutritive value, taste and odor, delivery service, budget wisdom, and company reputation.

While milk is, beyond doubt, a good food for human beings it is also a good culture ground for germs. Harmless and dangerous germs grow in it equally well. They may come from diseased cows or from diseased people. The diseases usually transmitted from infected animals are tuberculosis, undulant fever and septic sore throat, and milk contaminated by man may transmit typhoid fever, scarlet fever, diphtheria, dysentery, and diarrhea.

How is the consumer to know of the sanitary quality of the milk purchased? It has long been the practice of enthusiastic route salesmen to say, "The milk of the John Doe dairy is tested," as a part of the sales talk. In itself, that means nothing unless it is known who performed the tests, how they were conducted and just what were the results.

It is the duty of a health department to supervise the production and pasteurization of milk, and this includes inspection of buildings, equipment and handling, plus a bacterial examination of the milk itself. Many health departments do these things; many do not.

When they are done adequately the problem of the consumer's difficulty in selecting a source of supply is solved by placing a grade designation on the bottle cap. If the milk is of good sanitary quality the health department grants this dairy permission to label bottle caps Grade A. This means, in effect, that it is the best milk obtainable and is recommended for use. A consumer's support of a health department's decisions is a most important factor

(Continued on Next Page)

"To Greater Vision . . ."

Year after year men of science have striven to perfect examination of the eye, that greater precision in diagnosis might be obtained. Throughout those years every avenue of research has been explored—procedures of precision manufacture have been developed so that in modern ophthalmic instruments the practitioner might find the means of accurate diagnosis and correction.

The result of this painstaking effort is embodied in Bausch & Lomb ophthalmic instruments. In every stage of their development has been considered the need of the modern practitioner and throughout their design and manufacture is reflected the high scientific integrity of the country's outstanding manufacturers of ophthalmic instruments.

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(Continued from Preceding Page)

in an attempt to secure and maintain a safe milk supply. Suppose a distributor should leave a bottle of milk labeled Grade C at a home accustomed to receiving Grade A. This would be proof that this dairy has violated some important item of sanitation which the health department has discovered and that the milk is not of the usual quality, and, in fact, is potentially dangerous. The purchaser should immediately get in touch with the dairyman and ask for an explanation of the lowered grade. The possible loss of a customer will certainly supply this dairyman with an impetus to correct the insanitary condition that has caused the grade to be lowered. The health department by its action has tried to protect the consumer and his family and the consumer by taking this procedure is assisting the health department in community protection.

Milk provides almost every type of food element required by the human body, and so should be regarded as the most important single food. Its protein content aids growth and repair, the fat and sugar supply energy and warmth, its phosphorus and calcium are essential elements in nerves and bones. It contains vitamins A, B, C, D, and E in varying proportions, and these vitamins promote growth, furnish resistance to infection, aid digestion, stimulate appetite, strengthen the nervous system, build strong nerves and teeth and prevent and cure scurvy, rickets, and pellagra.

Flavor and odor are considerations in selecting a milk supply. An off-taste or peculiar odor of milk may be due to the physical condition of the animals, to feeding practices, exposure to certain metals, or to improper sanitation.

Delivery service can, of course, be readily ascertained by the prospective consumer. When possible, the time of delivery should be so arranged that the milk is promptly removed from porch to house, or, if not, a receptacle that is covered and insulated should be provided for its reception. Something should be known, too, about the transportation of the supply; if the milk is protected against extremes of temperature and if the truck is covered and clean.

The appearance of the bottle of milk should not be overlooked. A clean shiny bottle of milk, showing a reason-

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able cream line and a protected pouring lip is decidedly desirable.

Budget wisdom is an element frequently neglected by the purchaser. It is estimated that dairy products frequently constitute from 18 to 20 per cent of the total expenditure for food in the average American diet. Doctor Sherman, an expert on nutrition, states that food expenditure should be: Meat and fish, 12 per cent; milk and its products, 44 per cent; bread and cereals, 13 per cent; vegetables and fruits, 17 per cent; eggs, 6 per cent; sugar, 3 per cent; miscellaneous, 5 per cent.

A quart of milk supplies almost as much energy as a pound of steak, and about twice as much as a pound of chicken; it supplies nearly three-fourths the amount of calories needed by a year-old child; one-third that required by a boy of ten; and one-fourth the amount required by the average man or woman. All authorities agree that a growing child should have at least one quart of milk a day and that adults should drink at least a pint. Price comparisons considered, milk is the cheapest and best of all foods.

Company reputation is more important in the milk industry than in many other major industries, because not only is the product a most perishable one, but, if sharp practices are tolerated or attempted, the result may be extremely dangerous to the consumer. So it should always be the policy of the purchaser to ascertain if the dairy from which milk is supplied is content to put out a product that will merely "get by" or one that is maintained at a high standard.

Visual Standards for Licensure to Operate Motor Vehicles.*—In 1925 a report on visual standards for operating motor vehicles was submitted to the Section on Ophthalmology and approved by the House of Delegates of the American Medical Association. There were embodied in this report, first, recommendations of minimum visual requirements, and, second, that under certain conditions applicants with less than this minimum be qualified by special or county boards of licensure. The report further recommended: "In each state there shall be a board of physical licensure in each county, or one for several counties, consisting of two general practitioners or surgeons and one ophthalmologist." The second part of this submitted recommendation proved to be impracticable and therefore has not been embodied in law or in practice. The general purpose of this recommendation was to provide a certain degree of flexibility in the administration of the suggested visual requirements. For it was, and still is, generally agreed, on the one hand in the interest of greater safety and on the other of justice to some, that standards of good vision which are necessary for efficient operation of a motor vehicle cannot be arbitrarily fixed since the problem of safety depends on other factors as well; for example, the driver's natural aptitude, experience, and general mental and physical fitness. The lack of good vision may be compensated for by a high degree of efficiency in these other factors. But the appalling increase in the number of serious automobile accidents compels the further attention of all those interested in public welfare to study the problem of accident prevention.

During the year 1936, 38,500 deaths were due to traffic accidents, 110,000 persons were permanently injured and 1,230,000 were temporarily injured. With ever increasing numbers of automobiles in use and with increasing speed, the safety of the public demands the elimination of preventable accidents.

One study of the data relating to the cause of automobile accidents shows that the driver alone was responsible for three out of five accidents. Faulty mechanism was responsible for about 1 per cent. Condition of roadway, weather, traffic and, foremost of all, speed were responsible or contributed to motor vehicle accidents. In nearly all types of accidents, except faulty mechanism, all investigators agree that physical or mental defects of the driver have a part, good vision being of paramount importance. Since the driver alone is responsible for the major propor-

(Continued on Next Page)

* Preliminary report of American Medical Association Special Committee at Atlantic City Session: Dr. Nelson M. Black, Miami, Fla.; Dr. Harry S. Gradle, Chicago, and Dr. Albert C. Snell, Rochester, N. Y.

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

Clinical Laboratory of Drs. W. V. Brem, A. H. Zeiler, Roy W. Hammack and G. D. Maner, 657 So. Westlake Avenue, Los Angeles, California.

Zera E. Bolin, M. D., 490 Post Street, San Francisco, California.

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(Continued from Preceding Page)

tion of motor vehicle accidents, the problem facing the medical profession is fundamentally the establishment of practical methods by which to determine or measure the driver's ability to operate a motor vehicle.

The Section on Ophthalmology is interested in the visual phase of this problem, but this is necessarily complex. The visual function cannot be separated from the physical and mental, and a high degree of coördination of all these is most important to the skilful and safe operation of an automobile. The measure of good vision alone does not measure the driver's ability to interpret and to act on what is seen. However, good vision is essential in order to obtain the transmission of proper sensory impressions to these other essential functions.

To determine visual standards which are adequate to a greater degree of safety in operating motor vehicles, your committee has consulted the following for suggestions and advice: Council of State Governments, National Safety Council, American Automobile Association, National Society for the Prevention of Blindness, Bureal of Legal Medicine of the American Medical Association, United States Department of Commerce, National Bureau of Standards, National Research Council, and many students of traffic problems.

After consideration of the many phases of this problem, we submit the following recommendations:

1. *Bureaus of licensure shall be established in every state, and in as many subdivisions thereof as may be necessary.*

 (*a*) A license shall be issued to each individual only after determining the applicant's ability to operate a motor vehicle.

 (*b*) To test this ability actual road tests shall be made by legally appointed lay persons who shall be trained

(Continued on Page 30)

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in *The Saturday Evening Post* and other leading magazines.



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OF MANY BUSINESS MEN

MANY a business man pictures himself as a sort of modern Atlas—supporting the fate of the world on his shoulders.

He sincerely regards his work as indispensable to the success of the business, and recoils from anything that he feels might take him away from his job.

That's why it usually is so difficult to get such a man to pay proper attention to his health, even though he is troubled by persistent signs and warnings that something is wrong.

For at any suggestion that he heed these warnings—that he see his doctor—he says: "Yes, yes, I suppose you're right. But what if the doctor should order me to stop work for awhile? Who'd take care of my job? What would happen to the business?"

And the irony of it is that by his attitude he is inviting the very thing he fears! For one of the surest ways of encouraging a *serious* sickness is to neglect a seemingly *small* one. Heart and other organic diseases, stomach ulcers, and nervous disorders—diseases to which men in the so-called "prime of life" are particularly susceptible—thrive on neglect.

When you see your doctor he may, to be sure, prescribe a short rest. But isn't that better than a *forced long* rest later? He might say: "Take things a little easy. Leave the office an hour earlier at night." But isn't that better than driving on relentlessly until you're *carried* out of the office?

Let us hope, of course, that your disturbance will turn out to be a minor one—and that its treatment will be simple, its correction rapid. But whatever is wrong, you'll be better off if you start correcting it before it becomes really serious. The most sensible thing you can do, therefore, is to see your doctor *now*.

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SEE YOUR DOCTOR

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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(Continued from Page 28)

and instructed in adequate methods for detecting those who possess the necessary aptitude.

2. *Unlimited License:*
 (*a*) To those who pass the prescribed tests with an established rating, an unlimited license shall be granted.
 (*b*) Those who fail to meet established standards as a result of the tests shall be referred either to a duly licensed physician or surgeon in the community for more detailed examination to determine the nature of the defect and its correction when possible if the lack of ability is evidently physical, or, if the failure is evidently due to lack of skill, to a driver's clinic for training in operation until the necessary skill is acquired.
 (*c*) The physician, surgeon or expert shall make a report of his examination and shall submit recommendations with regard to the applicant's fitness to operate a motor vehicle, after training, treatment or correction of defects when such is possible.
 (*d*) The local bureau referring the applicant shall have final jurisdiction in disposal of all applications for license.
3. *Limited License:*
 (*a*) Some applicants with borderline defects or partial incapacities may be given a limited license; such limited licenses to state on the license card the limitation or restriction imposed and the cause for issuing such limited license.
 (*b*) No applicant shall be granted a limited license who operates a motor vehicle in public transportation.
4. *This report does not include specific recommendations for standards of physical fitness other than those factors relating to vision.*
5. *Visual Tests and Standards:*
 (*a*) To those authorized to conduct the visual examination, instructions shall be given in the use, purpose

(Continued on Page 35)

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EDITOR GEORGE H. KRESS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . FREDERICK C. WARNSHUIS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

DISCIPLINARY CODES OF MEDICAL SOCIETIES

Medical Society Membership as a Vested Right.—It has taken medical societies a long time to learn the important fact that, once a physician is admitted to membership in a county medical society, he becomes possessed of rights and privileges that can be taken from him only if charges are properly filed against him, and even then, only after a fair trial, during which all his legal and other rights have been meticulously safeguarded. If such procedures were lax and these fundamental rules were not observed, and if, subsequently, disciplinary action, in the form of censure, suspension or expulsion was carried out, then such a member would have the right to turn to the civil courts and there give a society, its officers and members an unhappy and, perhaps, rather an expensive experience.

* * *

Disciplinary Code of the California Medical Association.—County medical associations in California, and in other states, despite the belief of their officers that they were proceeding properly, have had, in a number of instances, just such unpleasant subsequent awakenings; and that is why a new disciplinary code of the California Medical Association (outlined in its by-laws, under Chapter II—Membership) was adopted several years ago. Great as was the improvement so effected, later experiences have indicated that even these new rules could be clarified.

* * *

"Disciplinary Procedure" Recently Adopted by the Los Angeles County Medical Association.—Attention having been called thereto by the chairman of one of its committees, Dr. Lowell S. Goin, the Council of the Los Angeles County Medical Association instructed his committee to outline a "Procedure in Disciplinary Actions," to be used in the future as its sole guide. The committee's report, as adopted by the Los Angeles Council on February 7, 1938, appears below, and its perusal and consideration are recommended to all component county units of the California Medical Association.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Disciplinary Action Must Be Based on By-Laws: "Resolutions" Are Inadequate.—In connection with this subject of disciplinary action, it may be well to remind every county medical society that no member can be legally subjected to discipline (censure, suspension or expulsion) because of violation of a "resolution" that may have been adopted at some previous meeting. A "resolution" may state that conduct of a certain nature is "disapproved" by the society, but membership can be taken away only after it has been shown, in a fair trial, that a member has violated the constitution and by-laws of a society. Nor is a "resolution" a by-law. When in doubt on these matters, component county societies are advised to write to the central office of the State Association requesting that the opinion of its legal counsel may be given, before any active steps for a member's trial are instituted. The importance of caution and care in all these matters can hardly be overemphasized.

* * *

A County Society Is the Sole and Absolute Judge on Qualifications of Applicants.—An equally important fact to keep in mind is this, that each component county society is sole judge of the qualifications of physicians whom it admits to membership. If the application of a physician is rejected by a county medical society, when it has acted in accordance with its constitution and by-laws, that judgment of rejection stands, and there can be no appeal to a higher body, such as the state or national associations; nor need a subsequent application from such a rejected member be considered, except as the county society, according to its own constitution and by-laws, may see fit to grant that privilege.

* * *

Quality Precedes Quantity in County Society Membership.—In California, there are a goodly number of physicians not members, yet who are apparently eligible to membership in their respective county societies, and it is proper that dignified efforts should be made to secure the affiliation of such colleagues. On the other hand, among nonmembers are physicians whose records and past or present affiliations give just cause for hesitancy in so important a matter as that of granting membership. Here the old policy, "When in doubt, wait, consider, and reconsider," aptly applies. For, as stated in the beginning of these comments, such physicians, once they are members, become vested with certain legal rights, to divest them of which is no easy or agreeable task. Here, also, "An ounce of prevention is worth a pound of cure."

* * *

The Text of the Recently Adopted Los Angeles County Disciplinary Procedures.—Because of the great importance of all these matters, the procedures recently adopted by the Los Angeles County Medical Association follow:

(COPY)

PROCEDURE IN DISCIPLINARY ACTIONS

Procedure to Be Followed in Citing a Member to Trial Is Presented in the Following Report of a Special Committee: Report Adopted by the Council of the Los Angeles County Medical Association on February 7, 1938

I. *Most complaints when received could be referred to the Committee on Professional Conduct* without any action on the part of the Council; and your committee recommends that the Secretary of the Association be authorized and instructed to use his discretion as to such reference; the Secretary to be further directed to report all such complaints to the Council whether they are referred to the Committee on Professional Conduct or not.

* * *

II. *On conclusion of its investigation of any complaint, no matter how received, the committee has two courses:*

(1) It may recommend no action.

(2) It may recommend citation of the respondent.

(*a*) It should be, and the committee recommends that it become, the duty of the committee to secure a sworn affidavit as to the matters complained of, if the complaint is made by a nonmember of this Association.

The complaint should first be reduced to a concise statement by the committee and thereafter sworn to by the complainant.

If the accusation is by a member of the Association, he should sign the complaint (but not the charges).

(*b*) On the basis of the signed statement by a member or an affidavit by a nonmember, formal charges should then be prepared by the committee and signed by them as a committee.

This forms a sort of indictment and serves two purposes:

(1) It removes the personal element present when A accuses B, substituting therefor an impersonal action by a committee engaged in the performance of its duties.

(2) It changes the nature of the charges from a biased accusation to a calm statement that the ascertained facts are such as warrant their evaluation by the Council.

* * *

III. *The form of the charges should be as follows:*

To the Council of the Los Angeles County Medical Association: Attention, Dr. ———, Secretary.

We, the Committee on Professional Conduct of the Los Angeles County Medical Association, having investigated the ———, hereby charge as follows: that ——— (member, or members) of the Los Angeles County Medical Association, has violated ———.

Said Section —— reads as follows: ———.

Your committee bases these charges upon the following information disclosed by its investigation heretofore referred to: ———

That your committee is informed and believes and therefore charges: ———.

Your committee believes that the foregoing acts and conduct on the part of said ——— constitute violations by said ——— of the section of the ——— (here insert by-laws or Principle of Medical Ethics, as the case may be) which has been previously mentioned herein. Your committee believes that the alleged acts and conduct, if found to be true, of said member of this Association, namely ———, who is herein charged with violations of ———, require disciplinary measures as provided in Chapter II, Section 2 (d), of the By-Laws of the California Medical Association and, therefore, prefers these charges.

Said Chapter II, Section 2 (d), reads as follows: "Acts and Conduct Subjecting Member to Censure, Suspension or Expulsion by Component County Society. Any active member of a component county society who has been adjudged guilty of a criminal offense involving moral turpitude, or who has been duly adjudged guilty by his society, in accordance with the procedural requirements of these by-laws, of gross misconduct as a physician or a surgeon or of a violation of any of the provisions of the professional conduct of his society or of the principles of medical

ethics promulgated from time to time by this Association or by the American Medical Association, shall be subject to censure, suspension or expulsion from his society by such component county society."

Respectfully submitted,

COMMITTEE ON PROFESSIONAL CONDUCT.

Date: ———

* * *

IV. *The details of service, certificate of service, notice of hearing,* and all of the other details set forth in Chapter II, Section 3, of the By-Laws of the California Medical Association should be meticulously followed.

* * *

V. *There should be no evasion* of the fact that the respondent who is being cited is to be tried; that the Council before which he is cited to appear is a trial body; or that he will be on trial when he appears.

* * *

VI. *The Chairman of the Committee on Professional Conduct should be assigned the definite duty of prosecutor,* the other members of the committee sitting as advisers.

* * *

VII. *The Council, which is in fact the jury,* should refrain from interrogation of the respondent or witnesses except in such instances as some question may be necessary to clarify some doubt existing in the questioner's mind. When there is such a question it should be addressed to the presiding officer.

* * *

VIII. *The Council should make a definite rule stating whether attorneys-at-law will be permitted to represent either side* in such a trial. The committee recommends that they be not permitted.

* * *

IX. *The respondent should be advised of his rights,* namely: that he may be represented by any member as counsel; (but if the foregoing recommendation (Item VIII) is adopted, it should be stipulated that he may not be represented by a member who is admitted to the Bar) that he, or his counsel, may cross-examine witnesses; that he may offer in evidence any records or documents that he deems fit; that he may enter objections as to testimony or to material in evidence; that he may address the Council in his own behalf; and that he has the right of appeal.

* * *

X. *A referee* should be requested in all cases.

* * *

XI. It shall be the *policy of the Council that the Chairman thereof shall remain as its presiding officer, but that all questions of procedure shall be answered by the referee, if any.*

* * *

XII. *On conclusion of the hearing,* the respondent, his counsel, if any, the Professional Conduct Committee, and the referee should be excluded and the verdict considered. The verdict should be ascertained by secret ballot in writing.

A time should be fixed in which briefs may be filed, and the Council should consider the evidence after such time has elapsed.

* * *

XIII. The Council shall establish as a policy, and shall recommend to the Board of Trustees that the Secretary shall be granted *authority to engage the services of a court reporter* for the purpose of securing a transcript of evidence at all trials.

* * *

XIV. *The Secretary of the Association shall advise the accused in writing of said accused's rights* under Chapter II, Section 3, Paragraph 5 of the By-Laws of the California Medical Association on a form on which shall be printed all of Chapter II, Section 3, Paragraph 5.

XV. *To avoid expressions of opinion, verdicts should be rendered as follows:*

"*Resolved,* That the charges against (name) be and hereby are dismissed" in case that the respondent is found not guilty;

or

"WHEREAS, (name), a member of this Association, has been charged with violation of certain sections or articles of the Code of Ethics; and

"WHEREAS, He has had a fair and impartial trial and has been found guilty;

"*Resolved,* That he be and hereby is (action taken)."

COUNTY MEDICAL SOCIETY HEADQUARTERS HOMES

The Official Journal's Plea for "Medical Buildings," as Made a Quarter of a Century Ago.—Twenty-five years ago, Editor Philip Mills Jones gave expression to a thought, neither then nor now new, but today even more worthy of serious reflection by all county medical associations of any considerable size. Editor Jones, in the following words (which appeared on page 152 in the "Twenty-five Years Ago" column of last month's issue), advocated homes for county medical societies:

> Have you thought anything about that suggestion in the last JOURNAL as to the county society owning its own building? It can be done by a good many—if not most—of the county societies in California. You all pay rent to somebody; why not pay it to the county society? It is merely a matter of finance, of getting together, and the getting together, in some places, seems to be the hardest part of the problem.

* * *

County Medical Societies Having More Than One Hundred Members Should Be Especially Interested.—A glance at the membership totals of the California Medical Association's component county societies (which, with five conjoint county units, each made up of more than one county, embrace fifty of California's fifty-eight counties; as listed on page 5 of the Membership Roster supplement of the February OFFICIAL JOURNAL) will promptly reveal the county societies credited with more than one hundred members each. Of organizations having such membership the California Medical Association possesses eleven: Alameda, Fresno, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Barbara, and Santa Clara. Why should not each of the societies mentioned (Los Angeles and San Francisco counties having already provided themselves with homes) consider financial ways and means, as well as location and plans, for the erection of headquarters homes? In Los Angeles County, several of the larger geographical branches (that of Long Beach, for instance, which boasts over 200 members) might well consider homes of their own. It is quite likely, if inquiry were made of the Federal Home Loan authorities, that plans could be devised whereby, with a showing of a basic investment or resources of 10 per cent (to be raised by initial voluntary contribution or assessment), it might be possible to secure a federal loan up to, perhaps, $6,000, with repayment on easy terms and low interest over a period of twenty years. If a lot were secured through donation or purchase, the initial hurdle would

have been cleared, and the remaining steps should bring no major hardships if ordinary budget caution were used.

* * *

Simple Headquarters Would Be in Order: Woman's Auxiliary Could Help.—An elaborate initial structure would not be necessary. A meeting hall, with shelvings for books, and a reading alcove, with anterooms, would answer all immediate needs. The woman's auxiliary in each county could lend a hand, both with furnishings and in the maintenance of such headquarters, and its library, clubhouse, and meeting-place accommodations. Why not, then, dignify your county medical society with a home of its own? The possession of headquarters property would not only add to the prestige of every association owning the same, but would have a stimulating influence upon the growth of the unit, and the development of finer fraternal and other affiliations. In our colleges and universities, the Greek-letter fraternities for many years have demonstrated the advantages of individual clubhouses. Surely, in the ancient guild of physicians, it should be attainable to duplicate what has been so often created and so successfully achieved by small groups of undergraduate students; and especially so today, when long-time, low-interest loans from federal sources may often be obtained on comparatively slender initial investment. We feel certain, also, that the established medical libraries of California will be happy to cooperate in starting local book collections, by donating duplicate volumes which otherwise must often be sold as waste paper.

* * *

A Special Committee on Headquarters Is in Order.—Why not, while the subject is ripe, have your own society appoint a special committee to look into this proposition? The officers of the California Medical Association will be glad to advise. For any members who may shy off at the thought of a local assessment needed to help purchase a lot, it will be in order to state that every applicant for membership in the Los Angeles County Medical Association today must pay, or sign a note to pay, the sum of one hundred dollars into the permanent quarters fund. That large county society, through fortunate investment some years ago, now has a headquarters and library building of unusual usefulness and attractiveness, and a home that is becoming an increasing benefit and joy to its members; and what has been done in Los Angeles and San Francisco can be repeated by other county units. San Francisco colleagues, in their annual dues, assess themselves even more heavily than do their fellows in Los Angeles. As already stated, the OFFICIAL JOURNAL of the California Medical Association became a propagandist for headquarters homes as long as twenty-five years ago. Why not, then, make an earnest attempt, in these years, 1938-1939, to prove whether such a desirable addition can be brought into being for your society? Surely, the proposal is worthy of earnest thought and discussion. "Where there is a will, there is a way."

SOME COUNTY HOSPITAL PROBLEMS: CONTINUED FROM FEBRUARY ISSUE*

County Hospital Articles in the February Issue.—In last month's issue, comment concerning certain conditions which had been brought to our attention was made under two captions: (1) "California County Hospital Bureaucracy! Which Way Leading?—State Medicine Through a Back-Door Entrance?" and, (2) "Los Angeles County Hospital Collections Bureau," this having as a subheading: "How Los Angeles County Charges the Indigent Sick for Hospitalization, While Accepting Gratuitous Medical Service to the Value of About Two Million Dollars Annually from Attending Physicians and Surgeons"; the latter article including some ten exhibits, and covering correspondence, the full Kern County Appellate Court decision, and other items.

To have printed the above in the OFFICIAL JOURNAL of the California Medical Association, and, after mailing, to have then sent copies to the Board of Supervisors or to the newspapers, would have resulted, probably, in little more than another experience with what so often takes place under such conditions, to wit, "move the report be received and filed." Therefore, and because the principles involved in the County Hospital conditions outlined were closely related to the State's welfare, the articles were released to the public press of Los Angeles two days in advance of the regular mailing date of CALIFORNIA AND WESTERN MEDICINE. It was heartening to note the prominence which the newspapers, of their own volition and without special request, gave to the discussion of these local county hospital problems. After publication of the charges in the press, several hearings were held, at which Los Angeles County officials and members of the executive board of the attending staff were present, the further study of the matter being then delegated to a joint group of the above parties. What the ultimate decision of the conferences will be is not possible, of course, to forecast; but that some of the conditions complained of will be remedied, is quite certain. For, not to modify certain of the present procedures must result ultimately in a popular outburst, with adoption of methods differing decidedly from those in vogue in the past. Elsewhere in this issue,† some additional, new evidence is submitted to substantiate statements made in the February issue.

* * *

The Essence of the Kern County Injunction. In this column, at this time, we would only emphasize the fact that, no matter how much legal and other language may be quoted or brought forward to the contrary, the really significant and far-reaching items of the Kern County Hospital Fourth District Appellate Court decision are the subdivisions (*a*) and (*b*) of Injunction Section 8

* See CALIFORNIA AND WESTERN MEDICINE, February, 1938, on pages 73 and 97.

† See report in Special Articles department, on page 216.

(see February issue, page 109, first column), which read:

. . . The following should be admitted:

(*a*) An indigent sick or dependent poor person.

(*b*) A needy sick and dependent, or partially dependent citizen in case of emergency. . . .

The other items which follow (*c*) to (*e*) relate only to exceptional cases involving, at any one time, but a very small number of citizens.

The crux of the Kern County Hospital decision, therefore, reaffirms what has been the contention of the medical profession, whose members in the Los Angeles County Hospital yearly donate professional services with money value in excess of two million dollars! Physicians of California hold that the Constitution and the Welfare and Institutions Code of California make it possible for the constituted authorities (the boards of supervisors) of the constituent counties to create and maintain institutions known as county hospitals, designed primarily for indigent citizens who are sick or injured. In such institutions, the citizens who belong to the indigent class shall be entitled to receive treatment; provided that, in case of emergencies, partially dependent citizens (meaning medically indigent persons, *i. e.,* citizens who, after providing themselves and their families with housing, clothing and food, do not possess means for adequate hospitalization or medical care) may also be admitted; these latter being expected to repay the county later, in proportion to their means. Nonindigent citizens have no legal right to hospitalization in county hospitals except in case of emergency, and are then legally obligated to pay the full costs of their hospitalization.

* * *

The Staggering Hospitalization Charges to Indigent Patients in Los Angeles County Hospital.—As stated in our previous articles, the County of Los Angeles, through its Department of Charities, has deemed it proper to practically demand repayment of hospitalization charges from all patients, both indigent and near-indigent, the statements so rendered for the period July 1, 1937, to December 31, 1937, inclusive, aggregating $2,366,779.30, with an estimated staggering total of $4,733,588.60 for merely the county's current fiscal year!

With only the sum of about $300,000 of this $4,733,588.60 possible of collection, and probably 90 per cent of the amount so collected coming from "partially dependent citizens," whose financial status, by any business-like method in the great majority of cases, should have been decided through social service investigation *prior to admission,* it seems almost self-evident that it is debatable whether it is good business policy to use a procedure that annually costs $109,383.09 to maintain, in order to make possible collections of only $300,000; the Collection Bureau, using methods, at the same time, so seemingly harsh that the indigent poor and their friends, to a probable number of, say, 500,000 persons out of a county population of 2,500,000, are driven to become, in many instances, more or less antigovernmental or bolshevistic! Surely something is wrong in a set-up capable of leading to such deplorable results. Letters received during the last several weeks from both physicians and patients attest to the above, and some examples are printed in this issue, on pages 216 and 219.

* * *

County Hospital Problems Are Being Studied by the California Medical Association Council. Los Angeles County, with its 3,000 patients in the County Hospital, its 4,000 tuberculosis sick in Olive View Sanatorium and adnexa, and 1,000 patients in the Infirmary of its County Farm (these latter housed there because of chronic diseases), presents, of course, a major problem all its own, the cost figures, naturally, assuming tremendous sums. However, what has been commented upon in the articles referred to has not been so much the quantitative phases, but, rather, the qualitative nature of the principles involved. And these principles come into play, more or less, in all the county hospitals of California, and are receiving serious consideration by the Council of the California Medical Association.

* * *

Each County Society Should Investigate Its Own County Hospital and Make Prompt Report.—As previously stated, each component county medical society, through its officers and proper committee, should make an early study of the admission and other requirements and procedures of its respective county hospital, sending a copy of the report thereon to the central office of the Association for the consideration of the Council. With full knowledge of factual information in these matters, gathered from all counties in the State, it would then be possible for the members of the constituted authority of the Association—the Council—to formulate plans and make report to the House of Delegates at the 1938 annual session, to be held in Pasadena. Let us repeat, the county hospital subject is important and vital to the interests both of the citizenry and the medical profession of the State, and is worthy of the earnest attention of every county medical society in California!

THE CRIMINAL INSANE

A Recent Case.—The article by Dr. Ruggles A. Cushman, Superintendent of the Mendocino State Hospital at Talmage, California, on the subject, "The Criminal Insane," printed on page 83 of the February issue of CALIFORNIA AND WESTERN MEDICINE, has attracted considerable attention in medico-legal circles, and deservedly so. Its appearance, at a time when, in Los Angeles, a jury brought in a verdict of manslaughter against a man who had killed his wife and his friend, and then, when the same jury, a few days later, on a separate plea of "not guilty by reason of insanity," affirmed that the perpetrator of the deed had been "insane" when the deed was perpetrated, made the presentation by Doctor Cushman's views and the discussion thereon most pertinent. In the case above referred to, the prisoner, subsequent to the

"insane" verdict, was sent to the psychopathic ward of the County Hospital, where alienists, appointed by the Court, were called upon to examine him and give their opinions as to his sanity. At the time of this writing, the Court in charge has not brought in its decision; but the opinion of men on the street is that the prisoner will be given his liberty as a "sane" person.

In this particular case, which, owing to its unusual nature, was given much space and exploitation in the public press, both locally and elsewhere, there was the usual spectacle in the trial, of medical witnesses being pitted one against the other, giving their expressions of opinion on hypothetical questions. What took place was, as Doctor Cushman so aptly stated when he wrote:

> Another court proceeding which brings the psychiatrist into popular disrepute is the manner in which he must testify as an expert.

In the case here under discussion, the prisoner is now to be examined by a new group of psychiatrists, and, quoting Doctor Cushman again, there comes into play the next step, namely, that on the

> successful plea of insanity, [concerning] these individuals . . . , unless [they be] suffering from a definite psychosis, the *hospital staff can only testify that they are sane, and the judge is bound to release them.**

* * *

California's Laws on the "Criminal Insane" Need Amendment.—Doctor Cushman's proposed amendments to the Penal Code's "1026 law," along lines such as are in operation in Colorado, Ohio, Maine, Vermont, and New Hampshire, are worthy of careful consideration; he stating the proposition thus:

> . . . The law should be amended and supplemented by provision that, before a prisoner is tried upon his insanity plea, he shall be sent to a state hospital for one month or longer, if possible, for continued observation. If found actually suffering from a mental disease, he could be detained until recovery without the expense and ordeal of a trial, and then be tried on a fair basis. If found sane by the hospital staff, his opportunity for escaping by means of an insanity plea would not be so favorable. Also, justice would be done to that type of offender who is actually suffering from a psychosis, but who, due to popular feeling against his antisocial act, is often dealt with most unjustly.

A proposed act submitted to the 1937 California Legislature, which would have accomplished the above, failed of enactment, but effort to secure its passage will be made again when the Legislature convenes in 1939.

Doctor Cushman's paper, with its discussion, has distinct educational value, and it is to be hoped that reprints may be made and distributed during the next few months, not only to legislators, but to medical and bar associations, service and other clubs. This is to be wished for, in order that presentation of facts and the remedial measures advocated may elicit support from the citizenry of the State, thus making much-needed legislation in these matters more possible of enactment next year. Certainly, there is need of improvement in the present laws.

* A few days later the decision of "sanity" was handed down, and for those who are interested, a press item is reprinted in this issue, on page 212.

A "HUMANE POUND LAW" INITIATIVE TO BE ON THE STATE ELECTION BALLOT IN NOVEMBER, 1938

A Proposed Antivivisection Measure: But Under a New Name.—Most members of the California Medical Association are aware that California "antivivisectionists" have secured, under the euphonious title, "Humane Pound Law," the necessary 186,380 signatures of voters for submission of a new proposed initiative law—in this instance, one dubbed the "Humane Pound Act," and that it will be given a place on the November, 1938, State election ballot for decision by the State's electorate as to its adoption.

Editorial criticism concerning this measure, which its proponents hope to give a place on the statute folios of California, was made in the *Journal of the American Medical Association* in the number for February 19, 1938. The importance of the issues involved, therefore, warrant reprinting of these *J. A. M. A.* comments:

California's "Humane Pound Law" and Medical Research

Unscientific movements are constantly promoted, based on misinformation, prejudice, emotionalism and cynical racketeering. Chiropractors, naturopaths, naprapaths, herbologists and all sorts of -paths, -ologies and -isms ally themselves with other quacks and sentimentalists to oppose medical research, which exposes the hollowness of their pretensions. The antivivisectionists have made hay in the California sunshine. Fortified with some prominent theatrical names and disregarding the absence of scientific qualifications in such sponsorship, the antivivisectionists have frequently attempted to throttle research in California and in other states.

In 1932 and subsequently, a determined attempt was made to interfere with the use of dogs from the San Francisco pound, by the medical schools in the San Francisco Bay area.[1] This attempt was frustrated by the combined vigilance of the medical profession and public health authorities. Undeterred by this failure, the "antis" in 1937 turned to the initiative provided under California law and circulated a petition for a so-called Humane Pound Law. The crucial provision in this law is that dogs and cats shall not be delivered to medical schools from public pounds. This means that research involving dogs would be prohibitive in price, since the breeding of dogs for research purposes is not practical. The petition received the requisite number of signatures and will appear on the ballot at the election of November 8, 1938. Many of the signers of the petition obviously did not understand what they asked for with their signatures. As was pointed out in our discussion of the Colorado proposal last week, many signers fail to understand the ultimate effects of the petitions to which they affix their signatures. Many estimable persons, imbued with the spirit of kindness to animals, may feel inclined to vote for this pernicious legislation unless they are fully informed in time as to what it would mean in the harassment of medical education, the hampering of medical research, and interference with the manufacturing and testing of drugs and biologic products.

A California Society for the Promotion of Medical Research is the answer of the enlightened people of California to the challenge of the antivivisectionists and their cultist, faker, faddist and fraud-monger allies. Among California's leading citizens who will be active in the society, or will lend it their moral support and influence, are Ray Lyman Wilbur, president of Stanford University; Robert Gordon Sproul, president of the University of California; the Rt. Reverend Charles A. Ramm, Monsignor St. Mary's Cathedral, San Francisco; Rabbi Irving F. Reichert,

1 Question Is of Facts, San Francisco *Chronicle*, July 11, 1932.

Temple Emanu-El, San Francisco, and Rev. William Kirk Guthrie, D. D., San Francisco. Organization and membership work is proceeding actively.

The forces seeking the adoption of the so-called Humane Pound Law appear to be well financed and give every evidence of determination to achieve their purpose. They have heretofore demonstrated their total immunity to any appeals to reason. Dominated as they are by their mistaken ideas of humanitarianism, by which, if successful, they would precipitate on the people of California a deluge of disease, pain and death, they cannot be persuaded. They must be defeated. This issue is not confined to California. Just as this law is not primarily a humane pound law, but an entering wedge for intolerable restrictions on the freedom of scientific research, so its adoption in California will be the signal for renewed campaigns in other states. If anyone doubts this, the following quotation from an antivivisectionist publication should be convincing: "... there is but one honorable stand to take, and that is to talk, write and work for the *complete abolition of vivisection*"[2] (capitals in original). The medical profession of California and its enlightened allies, the dental and veterinary professions and many of California's leading citizens, have the welfare of their state and its people as much at heart as any crackbrained coterie of false humanitarians can claim to have. They are backed by considered opinions based on scientifically demonstrated facts which underlie the modern record of health improvement through the application of the fruits of research.

The medical profession has always stood for the public health against those fanatical groups who, offering nothing constructive, would tear down the whole structure of scientific research. It is time the public helped in its own defense. The California Society for the Promotion of Medical Research is a step in the right direction. It should become a permanent organization, national in scope, adequately supported with money, similar to the British Research Defense Council. The American Medical Association has long had a Committee for Protection of Medical Research. With the coöperation of the Bureau of Health and Public Instruction, this committee has helped to keep the antivivisectionists partially in check by cooperating locally with medical schools and medical societies. Numerous efforts directed at crippling research have been defeated. All this is not enough. Promotion is needed as well as defense. A national society of enlightened persons in all professions, in business, in industry and in public life, is needed to preserve the country from the evil influence of this distorted antivivisectionist propaganda.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 197.

[2] The Animal Helper, Vol. 7, January, 1938, published by N. F. Whitaker, Dayton, Ohio.

Hepatic Involvement in Exophthalmic Goiter.—Retzlaff reviews the literature and describes five cases that were observed at the university clinic in Königsberg. Although the literature indicates that a knowledge of a toxic impairment of the liver is based chiefly on pathologic anatomic studies, the cases reported here indicate that in all of them the signs of hepatic impairment were already demonstrable during life. Icterus, the most typical symptom, and an increase in the bilirubin content of the blood were present in three cases. The fact that in two of these three cases the condition improved again indicates that the icterus which develops during exophthalmic goiter does not have the unfavorable prognosis (fatal outcome) that has generally been ascribed to it. On the basis of clinical studies and necropsies the conclusion is reached that parenchymal and functional disturbances of the liver are not a rarity in patients with exophthalmic goiter but that they can be observed occasionally, especially in the severe forms of exophthalmic goiter.—*Zeitschrift für Klinische Medizin.*

EDITORIAL COMMENT†

CONTROL OF CERTAIN BLINDNESS HAZARDS AMONG MYOPIC CHILDREN AND ADULTS

Near-sighted or myopic children, as well as adults, may have a separation of the retina from minor injuries, often so trivial as hardly to impress the memory as especially important among the ordinary bumps and bangs of daily play or routine. From among these myopic individuals, during a period of time, will originate two-thirds or three-fourths of all the separated retinas which probably will have to be operated upon to prevent blindness—perhaps of their only useful eye—because, when it occurs in the first eye, our early records indicate that, without special care, it occurs finally in the last eye with disturbing frequency (more than one in four).

Fortunately, this threat to the second eye has been enormously reduced by hazard-avoiding habits learned by the patient and guardians during the operation and protracted postoperative period of intensive training. Thus, today records are clearly showing that often a "stitch in time saves nine," because the last eye is easily eight times as valuable as the first eye, and we can often do the operation now, leaving just one knotless running stitch, removable without lid opening, on the fifth day.

This experience leads us to suggest that some of our rules be used preventively, beginning in school days:

1. Insist on an eye examination report, showing definitely the amount of myopia when present. (Fifteen cases of low myopia should be found per hundred individuals examined, on an average.)

2. At least do not encourage myopic children to engage in rough sports, and gymnasium or other strenuous exercises. To avoid hazard they should not be permitted to engage in or loiter near games involving flying objects such as stones, balls, sticks, hands, or fists.

(*a*) Advise against racing, physical competition and combat.

(*b*) Discourage the use of the various modifications of the old doorknob method of pulling teeth. Pulling hair is just as bad.

(*c*) Advise against sit-down strikes; they often lead to brawls, and if tear gas, or even dust particles get into the eye, the consequent rubbing is a vicious producer and subsequent augmentor of the separated retina.

(*d*) Warn against the evils of rubbing the eyeballs strongly when washing the face or at any other time. When rubbing is irresistible, teach them to rub the lid margins against the lower bony rim of the orbit—not against the eyeball.

(*e*) Teach them never to think of all activities in terms of the hazards thereof, since the above

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

examples are only a few of the commonest. Eyesight is worth every precaution.

Without doubt, to whatever extent these or equivalent rules are followed, a corresponding reduction in the occurrence of blindness from separated retina will result.

410 Auditorium Building.

Clifford Walker,
Los Angeles.

"NATURAL IMMUNITY" VERSUS DRUG TOXICITY IN MALARIA

There is no drug, nor combination of drugs, at our disposal today which will completely rid an individual of malarial parasites. It is unwise, therefore, to attempt sterilization of all parasites during a primary attack of malaria. Relapses cease to occur naturally, in untreated humans, when the defensive mechanism of the host has managed to overcome the fever and attendant symptoms which the protozoa cause in nonimmune patients. No attempt should be made during the primary attack, in the opinion of the Malaria Commission of the League of Nations,[1] to continue treatment with the hope of preventing relapses. If treatment during the first recrudescence is not successful in preventing relapses, drug therapy of later recrudescences should be delayed as long as possible in order to permit the patient to acquire some defensive power.

Taliaferro and Cannon[2] have recently studied the cellular reactions during primary and repeated infections of monkey malaria in Panaman monkeys. This extensive study has been most carefully planned and carried out, and confirms the conclusions reached from previous studies on immunity in bird malaria. These authors have demonstrated that when the crisis occurs in monkey infections the phagocytosis of infected cells is suddenly increased. This, they say, is to be looked upon as an acquired immunity response in contrast to the phagocytosis which has gone on before the crisis and which is believed to be due to a natural immunity. It is the intensive phagocytosis at the crisis which reduces the infection to a low level, in spite of the fact that the parasites may continue to reproduce at their original rate.

In order to prevent relapse in malarial-infected humans, it would seem wise to wait until the first recrudescence has occurred and then to use specific drug therapy in such a way as to assist "rather than hinder the development of the patient's natural defensive forces." By repeating this plan with the same watchfulness during later recrudescences, *i. e.,* by using the specific drug at a later period and more sparingly than at first, "in most cases the patient becomes fortified or preimmunized against the disease to the extent that he not only ceases to suffer from relapses, but fails to have an attack when he is reinfected."[1]

For the treatment of an acute attack of any form of malaria the Commission recommends that either quinin or atebrin be used. For routine use either drug may be tried. Each has some disadvantages, but they are trivial in comparison with their merits as antimalarial agents. Usually one gram of quinin bihydrochlorid daily, for from five to seven days, is sufficient for the primary malarial attack. If atebrin is chosen, then 0.3 gram daily may be given for the same period. The Malaria Commission contends that "curative doses of quinin or atebrin for treatment of an attack should not be continued longer than seven days, and that treatment for five days will often suffice." Plasmochin is not recommended by the Malaria Commission for routine use.

When these principles are violated, serious consequences may result. The following patient is cited as an example of atebrin poisoning, which followed the injudicious use of antimalarial drugs.

Report of Case.—M. D., an American housewife, twenty-eight years old, acquired her first attack of malaria while visiting one of the atols near Tahiti. She had her first chill four days after she left the island en route to Panama. The parasites of benign tertian malaria were demonstrated in her blood. She was given quinin 0.66 gram daily for four days, and for the next three days daily intramuscular injections of quinin and urea hydrochlorid, the amount being unknown. She was then symptom-free for one month, but suffered her first relapse and again had parasites in her blood. Atebrin was administered in 0.1 gram amounts three times daily for eight days. Since the patient weighed 48 kilos at that time, the total dose given must be considered as approximately 50 per cent above the amount usually recommended. Within twenty-four hours after finishing the course of treatment, the patient's skin became deep yellow, she complained of persistent headache, and was nauseated and vomited. Her temperature became abnormally high, and she was conscious of an increased heart rate and was very weak. When first seen by us, fourteen days after she had started atebrin therapy, her skin was bronze color, but her sclerae were not discolored. The liver was enlarged and tender to deep pressure, but the examination was negative otherwise, except for the blood pressure of 100 millimeters of mercury systolic over 60 millimeters diastolic. Laboratory examinations of blood, including complement-fixation for syphilis, agglutinations against eleven antigens, icterus index and nonprotein nitrogen were negative or within the limits of normal. Feces, blood, and urine were negative for parasites. An electrocardiographic tracing was normal. The rose bengal hepatic function test showed a 42 per cent depressed function.

Comment.—It is our opinion that this patient has suffered from improper treatment, since the excessive amount of atebrin administered has presumably damaged her liver. There has been no attempt in this case to permit the natural defensive forces to overcome the infection. Not only should the dose of such a potentially dangerous drug as atebrin be based on body weight, but its use should be limited to the minimal amount which will abort a malarial attack or control symptoms. This changed attitude in antimalarial therapy should result in developing an increased host immunity in patients treated for this disease.

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1 Third General Report of Malaria Commission of the League of Nations, Quart. Bull. Health Organization of the League of Nations, Vol. 2, Extract No. 5, 1933.

2 Taliaferro, W. H., and Cannon, P. R.: The Cellular Reactions During Primary Infections and Superinfections of Plasmodium brasilianum in Panamanian Monkeys, J. Infect. Dis., 59:72 (July and Aug.), 1936.

THE PRACTICAL USE OF THE "ELIMINATION DIETS"

Trial diet may be used as a diagnostic measure whenever food allergy is suspected. It will be used with negative results in many instances, but much less often than is the Wassermann reaction or blood count. A test negative diet, eliminating the skin-reacting foods, may be tried first, but my continued experience confirms the general opinion that allergenic foods frequently fail to be indicated by positive scratch reactions, and when the intradermal test is used many reactions arise which are due to nonspecific irritants or to allergens which produce no clinical symptoms. Moreover, the intradermal test with foods often fails in the presence of active food allergy. Thus it is usually better to use trial diets, such as the elimination diets which exclude those foods which most frequently produce allergy, modified by definite scratch reactions or by the history of idiosyncrasies to specific foods.

For over twelve years I have been using the elimination diets in this manner for diet trial, and think that some comments on their manipulation and preparation can bear repetition.

Allergenic foods often must be eliminated for several days, and at times for one to three weeks, before definite evidence of improvement arises. In fact, the tissue changes resulting from long-continued allergy may be so marked, bordering on the irreversible type, and associated possibly with impaired vascular supply, or superimposed infection, that the maximum effect of the proper diet may not arise for several months. Therefore, too rapid decisions about the benefit to be derived from an elimination diet is unwise, and may, unfortunately, deny the patient relief from his chronic allergy. When elimination diets are to be used for more than a few days, the patient must be provided with sample menus which will assure a proper intake of calories, protein, vitamins, and minerals to maintain nutritional balance. Especially important is the weighing of the patient every few days, and regular interviews with the physician so that undesirable weight loss will not occur. The addition of calcium and vitamin D to the diet is usually desirable.

During such visits the physician must be certain that the patient is adhering to his diet. Possible mistakes in the kitchen, such as the stirring of the patient's food with a spoon that has touched milk soup or egg if they are excluded from the diet, should be prevented. Canned soups often contain unrecognized foods not included in the patient's diet. The possibility that so-called pure flours may be mixed with wheat or other ingredients must be appreciated. It is especially hazardous to entrust the making of bakery products to an ordinary baker in an unsupervised shop, since the temptation to include wheat or other forbidden food against orders is often too much to resist. Above all else, the patient himself is apt to taste a little food off the diet, or to take an interdicted food, thinking "a little will do no harm." Careful inquiry of the various foods eaten in friends' homes, restaurants, or hotels, will often reveal slight or definite mistakes. With such careful supervision of the diet, the patient will gradually develop the necessary scrutiny and care without which success with diet trial is impossible.

In every large city it will be necessary to have dependable bakers who will make bread, muffins, cookies, cakes, and other bakery products which contain specified flours and are devoid of various cereals, milk, eggs, and other ingredients, according to the physician's prescription. Such bakers, however, will need constant supervision, as shown recently by one who against orders included gluten flour in so-called wheat-free products. The patient, moreover, must be provided with recipes for bakery products, various desserts and candies if desired, which can be made at home, and their accurate use must be definitely assured by the physician.

If the physician uses the elimination diets routinely, the dietitians in the hospital or the nurse or assistant in the office can be trained to give instructions about the diet to the patient, but the determination of the accuracy with which the diet is being followed, and the determination of its effect, must be made by the physician himself.

The elimination diets can be prescribed very simply by ordering Diets 1 and 2 minus certain foods and plus others, or by ordering Diet 3 or Diet 2, alone or plus and minus specific foods. When routine diets 1, 2, or 3 do not give evidence of benefit, it may become desirable to use supplemental diets which have been previously described which contain one starch, one protein, a few vegetables or fruits, sugar, a specified oil, and salt, such foods being determined by the history, the results of previous dietary trial, and by positive skin reactions. The fact that patients may be sensitive to practically all fruits, all cereals, even to all meats, and at times to all vegetables in varying degrees, must be remembered.

In the use of elimination diets,[1] it must be emphatically stated that nutritional damage must never occur, and that undesirable weight loss must not be allowed. If the physician cannot arrange menus which prevent these undesirable results, diet trial should be promptly discontinued.

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REVERSIBLE GERMICIDES

It has long been recognized by professional bacteriologists [2] that the phenol coefficient, as determined by recommended standard techniques, is not a reliable index to the therapeutic usefulness of surgical antiseptics. While pneumococci and streptococci, for example, are readily killed in the test tube by dilute solutions of mercurial salts, the treatment of pneumococcus or streptococcus peritonitis with the same or even more concentrated mercurial solutions rarely gives curative results. Such antiseptics usually cause an earlier death of

1 Rowe, Albert H., M.D.: Clinical Allergy. Lea & Febiger, 1937.

2 Leonard, G. F.: J. Infect. Dis., 48:358, 1931. Birkhaug, K. E.: J. Infect. Dis., 53:250, 1933.

the inoculated animal than the untreated control. Methods for the therapeutic (or *in vivo*) titration of surgical antiseptics, therefore, have been sought by numerous investigators. One of the most promising of these is currently proposed by Dr. George A. Hunt[2] of the Department of Bacteriology, Washington University School of Medicine.

In the Hunt therapeutic titration, 0.1 cubic centimeters of a 50 per cent dilution of a twenty-four-hour broth culture of an "invasive strain" of Staphylococcus aureus is injected intracutaneously into a shaved area on the abdomen of mice. The hypodermic needle is dipped in India ink before making the inoculation, so as to leave a permanent tatoo mark at the site of injection. This injection causes a local inflammatory reaction from 3 to 10 millimeters in diameter, with subsequent suppuration, necrosis and scab formation. Desquamation and spontaneous healing is the usual end-result; in only two of the several hundred control mice thus far injected by Doctor Hunt, was there perforation of the abdominal wall with the development of fatal peritonitis.

The antiseptics thus far tested by the St. Louis bacteriologist include "disinfectant I" (chlor-iso-octyl-resorcinol), merthiolate, metaphen, mercurochrome, oxyquinolin, chlorazene, and hexylresorcinal. These antiseptics were tested as aqueous solutions twenty times the minimum concentration necessary to kill Staphylococcus aureus within ten minutes in the test tube. The test dose was usually 0.1 cubic centimeter of this multilethal concentration injected through the tatoo mark on the skin.

"Disinfectant I" was studied in greatest detail. This resorcinol product has a phenol coefficient of 1800 when dissolved in distilled water, reduced to a coefficient of 500 in the presence of one per cent serum. "Disinfectant I" was able to prevent the formation of the skin lesion in mice if administered at the same time the area was infected. Given one hour after infection, it prevented the formation of the lesion in only one mouse out of four. Administered three hours after infection, it had no demonstrable prophylactic or curative effects.

Even more discouraging results were obtained with merthiolate and metaphen which were without therapeutic effects even when the multilethal antiseptic and the staphylococcus culture were mixed prior to intracutaneous injection. Merthiolate and metaphen, therefore, are presumably "reversible germicides," rapidly dissociating from the staphylococci in the presence of mouse tissues.

"Reversible germicidal action" was first suggested as a biologic possibility by Mueller and Gegenbauer[3] about sixteen years ago. Doctor Hunt confirmed this reversibility by repeatedly washing merthiolated and apparently dead staphylococci with salt solution. Fully 90 per cent of the presumably nonviable staphylococci were restored to full viability by such washings, even after two to seven hours' contact with the multilethal antiseptic. By treating the same apparently nonviable merthiolated staphylococci with H_2S, practically 100 per cent of them were fully resuscitated. The standard phenol coefficient technique suggests that staphylococci are killed within five minutes by exposure to this concentration of merthiolate. "Revitalizations" of apparently dead bacteria, even after 100 days' exposure to mercury salts, have been reported by certain European investigators.[3]

In contrast with this resuscitation, Doctor Hunt found that the germicidal actions of "disinfectant I," oxyquinolin, chlorazene or hexylresorcinal are not "reversible," "revitalization" being impossible after only thirty minutes' exposure to these antiseptics. Doctor Hunt found that even these "non-reversible" disinfectants would not prevent the formation of the experimental skin lesion in mice if administered later than two hours after inoculation. None of them was capable of shortening the time of healing, once the staphylococcus infection was established in cutaneous tissues.

Whether or not more encouraging therapeutic results could be obtained with intracutaneous injections of specific antiserums, enzymes, endocrine products or other physiologic stimulants, has not yet been studied by this technique. It has been shown by Bronfenhrenner and Sulkin,[4] however, that local applications of bacteriophage usually do more harm than good in experimental staphylococcus skin infections in rabbits.

It is of interest in this connection that priority for the discovery of "reversible germicides" should conceivably be given to Doctor Mudge of the University of California (Davis), who has hesitated to report many of his results for fear of unfavorable publicity. "Bacterial death" as a "reversible phenomenon" or "death as a reversible chemical reaction" might readily have been misunderstood by nontechnical readers.

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Stanford University.

2 Hunt, George A.: J. Infect. Dis., 60:232, 1937.

3 Mueller, A.: Arch. f. Hyg., 89:363, 1920. Gegenbauer, V.: Arch. f. Hyg., 90:22, 1921.

4 Bronfenhrenner, J., and Sulkin, S. E.: Proc. Soc. Exp. Biol. and Med., 32:1419, 1935.

Just as there has been evolution in the content of public health knowledge, there has been also evolution in its administrative procedure. The primitive conception of applied public health was a service to be brought into action to control the spread of epidemic diseases, purely as an emergency measure. The accumulation of scientific knowledge relative to the nature and causes of preventable diseases, however, has made it more and more certain than by conscious planning and alert vigilance by organized health forces on continuous duty, epidemics might in large measure be forestalled and many of the most serious endemic health problems which would otherwise go unchallenged might be successfully overcome. Unfortunately, the great majority of our rural communities in this country have as yet made no preparation for any kind of health service beyond the emergency phase, and precious little of that. As evidence of the fact that concerted effort and conscious planning have only very recently been introduced into our governmental machinery, it should be noted that the first state board of health was organized in Massachusetts in 1869, and was followed two years later by the organization of the State Board of Health of California.—The Health Officer.

ORIGINAL ARTICLES

DURAL DEFECTS: HOW IMPORTANT IS THEIR SURGICAL REPAIR*†

AN EXPERIMENTAL AND CLINICAL STUDY UPON HETEROPLASTIC AND AUTOPLASTIC DURAL GRAFTS

By Mark Albert Glaser, M.D.
and
Clinton H. Thienes, M.D.
Los Angeles

Discussion *by Edmund J. Morrissey, M. D., San Francisco; Frederick Leet Reichert, M. D., San Francisco; Howard W. Fleming, M. D., San Francisco.*

DURAL defects caused by trauma, or produced by the removal of tumors of the brain, or the excision of cerebral scars, may or may not be repaired. If these defects are to be repaired, direct closure of the dura by suture, or the use of heteroplastic or autoplastic grafts may be utilized.

Various reasons have been advanced for the use of dural grafts. The earlier investigators were firm believers that the insertion of a graft prevented the formation of adhesions, and thus were a large factor in the prevention of posttraumatic epilepsy.

At the present time, the closure of dural defects by the use of grafts is a question for surgical debate. It is believed by some that a dural graft is entirely unnecessary, and at times may even be harmful because of its foreign body reaction, and its aid in the formation of excessive adhesions.

POINTS IN FAVOR OF DURAL GRAFTS

Those who favor the use of dural grafts quote the following reasons for their usefulness: (1) the prevention of rough edges of bone irritating the brain; (2) to close a dural defect after the removal of a large meningioma, or a cerebral scar and thus prevent surface adhesions; (3) to form a watertight closure after the removal of tumors or scar, provided the ventricle has been opened; (4) to prevent the formation of a brain fungus following depressed fractures or tumors, provided the intracranial pressure is high; (5) to prevent the development of meningitis following depressed fractures, which could arise secondarily from an infected scalp; (6) to form a definite layer over the surface of the brain so that, in cases of depressed fracture, fragments of the bone removed may be inserted in place to form a bony union.

AUTHORS' STUDIES

For the purpose of determining whether a dural graft is necessary, and to further determine if a dural graft is to be utilized, whether a heteroplastic or an autoplastic graft is more suitable, a series of twenty-four operations were carried out upon dogs, and a small series of clinical cases were studied. In this group of experiments the relative merit of dural repair was studied by the use of fascia lata, animal membrane, and a blank dural opening. These animals were operated upon under aseptic technique. The temporal muscle was stripped away from the calvarium under anesthesia, and a half-inch by one-inch opening was made in the skull. The dura was not injured. An area of dura of approximately the same size was then resected, without injury to the underlying arachnoid. This dural opening was left intact in a certain proportion of these animals, and in others a piece of fascia lata or animal membrane was sutured in place. The animal membrane utilized was sheep intestine which had been sterilized and tubed. These animals were observed for a period of twenty-four hours to one year.

EMBRYONIC BACKGROUND

The dura mater develops from the embryonic mesenchyme which early grows out as a covering to the neural tube. The mesenchyme condenses and splits and differentiates into scalp, bone, dura, arachnoid, and pia mater. Over the brain the dura mater is a single dense fibrous membrane, which may be subdivided into a denser outer layer of collagenous fibers, loosely adherent to the skull and serving as periosteum, and an inner looser layer of collagenous and yellow elastic fibers. The venous sinuses of the skull lie between these two layers. At the foramen magnum the outer layer separates from the inner, to become the periosteum of the vertebrae, the inner layer remaining as the dural covering of the spinal cord. The dura mater is loosely held to the inner surface of the skull by prolongations of its fibrous meshwork, and to the arachnoid membrane by delicate tissue bridges. Jordan makes the statement that the dura is rich in lymphatics, but Weed contends that these spaces are not true lymphatics lined with endothelium, but are merely areolae in the dense membrane. The vascularity of the dura mater is attested to by all writers. The large vessels are confined largely to the outer layer, while the vessels of the inner layer are fine and numerous. Hassin describes the dura mater as characterized by lacunae and numerous interstitial spaces containing nests of arachnoid or mesothelial cells. The characteristic cell is the fibroblast, but there may be found also histocytes and plasma cells. The outer layer is said to contain more nuclei than the inner. Where not attached to the bone, the outer layer is covered by a thin endothelioid coat. The inner surface more nearly resembles a true serous surface, being lined by a thicker type of endothelioid cell.

SURGICAL REPAIR OF DURAL DEFECTS

The repair of the dural defects by surgical means was first carried out by Sacchi in 1893. He recommended that the osseous disk of a trephination be turned around so that the periosteum approximated the dural defect. Abbe, in 1895, referred to a patient of Beeches', wherein gold foil had been employed to cover the raw area left after the separation of subdural adhesions. He, however, preferred rubber tissue. Since this pioneer

* From the Pharmacological Laboratory of Prof. C. H. Thienes, University of Southern California, Los Angeles.
Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 3–5, 1937.
† List of references will appear in the reprints.



Fig. 1.—A section of the skull has been removed. The dura is seen on its inner aspect. The two cranial defects are visible on both sides. On the right side, animal membrane has been sutured in place. On the left side the dural defect has been left open. Note how the space has been covered by the new growth of dura. It is from these sections that material has been taken for microscopic studies. Time after operation, five weeks.



Fig. 2.—Section taken three days after surgery. Note the thick clot which has formed over the brain and the fascia lata graft at the base of this clot. Microscopic sections were taken directly through this area.

work, many different tissues have been suggested for plastic operations upon the dura. Among those advocated were heteroplastic and autoplastic fascial transplants used alone, or in combination with muscle and fat, skin muscle, splitting of the intact dura, peritoneum, periosteum, amniotic membrane, veins, arteries, hernial sacs, egg membrane, tunica vaginalis, celluloid plates, laminated catgut, dog peritoneum, blood vessels of the calf, and finely scraped intestine of the sheep.

Autoplastic fascial transplant was first introduced by Kirschner, and was also advocated by von Saar, Kleinschmidt, Smirnoff, Denk, von Ebert, Hill, Barany, Gille, Neuhoff, Jeger, Alissandri, Halstead, and Caylor. Peritoneum was first utilized as a dural graft by Kocher and Beresowsky. It was further investigated by von Saar, Kolaczek, Smirnoff, Finsterer, etc. Peritoneal transplants were considered unsatisfactory because of the difficulty in obtaining them and, further, the fact that they adhered quickly to the underlying brain. The use of adipose tissue alone, or in combination with fascia, was utilized by Smirnoff, Rehn, Körte, Marchand, Bode, Koennecke, Drevermann, Byford. The use of periosteal grafts for the filling of cranial and dural defects was first suggested by Sacchi in 1893. This idea was confirmed by researches of Wolf, Koenig, Durante, Rhigetti, von Hacker, Delangenière, and Kerr. Though the primary purpose of the periosteal graft was to cover cranial defect, some attention was paid to regeneration of the underlying dura. Splitting the dura in half was first suggested by Bruning, and was independently described by Elsberg, and also utilized by von Eiselberg and Dobrotvorski. The technical difficulty in dividing the dura prevented its widespread use. The use of celluloid was advocated by Finsterer and von Eiselberg. Penfield and Peet believed the use of celluloid is quite valuable in preventing adhesions of the dura to the overlying scalp, and recommend its use in traumatic cases. Finely scraped intestine of the sheep was advocated by Hanel, and methods for disinfection of this membrane was suggested by Hofmeister and Taddei. Catgut applied in strands and laced into a network has been considered superior to all substance previously utilized, and absolutely prevented adhesions to the underlying brain (Righetti, Dainelli, Caporale, Caporale e Bertini, De Bernardis, Caporale and De Bernardis). Less common substances advocated, and more experimental in nature than practical, were the blood vessels, especially the vena cava, Unger and Bettman; hernial sacs and dog peritoneum, Finsterer; egg membrane, von Saar; tunica vaginalis, Kocher; omentum, Kozireff; viable muscle, Dixon; epithelium, Roux-Berger and Ballance; and umbilical cord by Perimoff. Experimental studies carried out by Trotter, Sayard and Harvey, and Penfield, supplied definite proof that the dura regenerated itself spontaneously, sufficient to cover any traumatic or operative defect.

In spite of the numerous substances suggested to close dural defects, the present consensus of opinion is that the most suitable is autoplastic fascia. If the defect is small, temporal muscle fascia is utilized. If it is large, fascia lata is recommended.

EXPERIMENT PROCEDURES

The experiments were performed upon a series of dogs; the first group, studied from twenty-four hours to one year, consisted of fascial transplants; the second group consisted of animal membrane

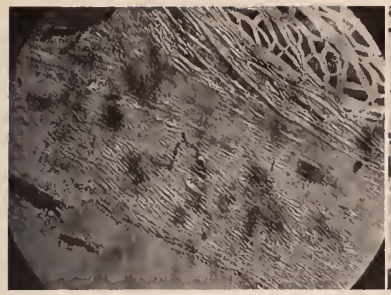


Fig. 3



Fig. 4

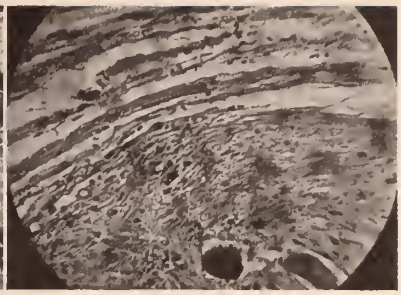


Fig. 5

Fig. 3.—Dura removed. Three months after operation. Thick layer of dura formed; few cells; bone formation at edge.

Fig. 4.—H. G., age thirty-nine, dural defect with the insertion of a graft, six weeks after surgery.

Fig. 5.—High power. Fascia inserted. Five weeks after operation. Note young fibroblasts, foreign body giant cells, plasma cells, and clasmatocytes.

grafts; and in the third group the dural opening was not covered in any way. These animals were sacrificed by intra-arterial formalin injection. The stains utilized in this study consisted of hemotoxylin and eosin; Mallory's phosphotungstic hemotoxylin stain for fibrils; Mallory's aniline blue-orange G stain for the presence of collagen; and Laidlaw's silver stain for reticulin.

Upon gross examination, the muscle was adherent to the newly formed dura. The defect was entirely closed and smoothly healed on the undersurface. In all three sets of experiments, the gross appearance of the newly formed dura was the same. The dura was adherent to the overlying bone, and when the skull was resected came away with the bone, leaving a free, non-adherent brain beneath. There were no adhesions whatsoever to the underlying arachnoid. This, of course, had not been injured. In one case where a small cortical blood vessel had been injured, and in another where an excessive amount of bleeding had occurred over the surface of the brain, small fibrous strands of adhesions were attached to the brain (Fig. 1). Sections taken through the surface of the brain were entirely normal. In those experiments wherein the dural defect was left open, a thin clot was present in the first twenty-four hours, but within a three-day period a thick clot had formed (Fig. 2). In order to study these sections, a wedge of brain and clot were excised through the bony defect, thus preserving the surface of the brain and the clot in one adherent piece.

In the group wherein the dural defect was not replaced, a definite membrane was visible within seven days, which became quite apparent on the tenth day. On microscopic examination, the process of repair consisted of formation of granulation tissue with a definite outgrowth of fibroblast from the muscle and the dural edge. There was no clear indication that there was a transition of the mononuclear cells of the blood. The clasmatocytes, or wandering tissue cells, as well as occasional polyblast, were present (Fig. 3). In a clinical case, the newly formed dura was evident six weeks following surgery, and here again new cell formation seemed to arise from the fibroblasts of the muscle and dura, and not from the blood-clot (Fig. 4).

The second series of animals was followed over a similar period of time. Fascia lata and temporal muscle, however, were utilized to cover the defects. The process again was one of repair with a definite invasion of a similar cell structure, except that foreign body giant cells were in evidence. Within a five months' period, phagocytosis of the fascia had taken place, as well as the laying down of calcium. Within nine months there still was evidence of the fascial membrane, while within a period of a year the presence of calcium was the only indication that foreign body had previously existed (Fig. 5). In a clinical case a similar histological picture was present, and coincided in every detail with the animal experiments (Fig. 6).

In the third series, animal membrane was utilized, which proved to be as satisfactory as the

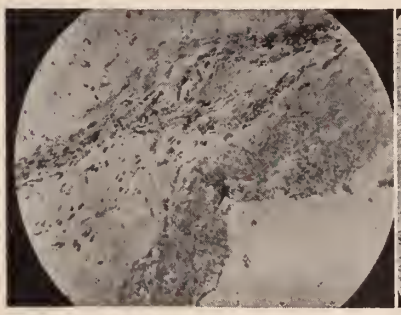


Fig. 6



Fig. 7

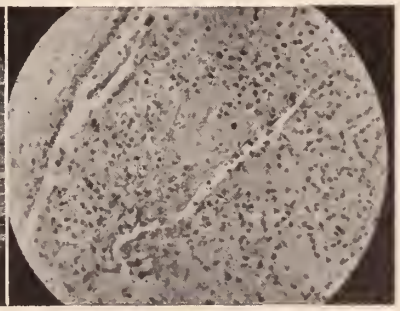


Fig. 8

Fig. 6.—M. L., age ten. Fascial graft five months after insertions.

Fig. 7.—Membrane inserted. One year after operaton. Membrane apparently completely absorbed. Dense layer or dura formed; slight infiltration of small round and plasma cells near pia.

Fig. 8.—R. B., age thirty-six. Animal membrane graft, eight months after surgery.

fascia, both as to its ease in application and the resultant histological picture. The same type of cell took part in the reaction, and at the end of a year complete absorption had occurred (Fig. 7). In a clinical case, studied eight months after the introduction of the graft, the membrane was quite apparent. It was entirely surrounded by fibrous tissue. The dura about the membrane was thicker than the surrounding area, and there were no adhesions (Fig. 8).

CONCLUSIONS

1. Experimental and clinical studies indicate that the use of either a heteroplastic or autoplastic graft for the repair of dural defects is entirely unnecessary.

2. Should one feel inclined to use a dural graft, heteroplastic animal membrane is equally as efficient as autoplastic fascia.

3. Dural defects caused by surgical procedures or depressed skull fractures without injury to the underlying arachnoid spontaneously repair themselves.

4. If the arachnoid is not injured, adhesions will not form between the dura, arachnoid and brain, but will form between the overlying skull and periosteum, as well as fascia and muscle.

5. Both types of grafts are entirely absorbed within twelve months.

6. The cells that form the new dura are apparently derived from the overlying fascia and muscle and from a peripheral outgrowth of dural cells, which arise from the cut margin of the dura.*

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DISCUSSION

Edmund J. Morrissey, M.D. (330 Medical Building, San Francisco).—The work of Doctors Glaser and Thienes is an excellent and timely piece of experimental research. Their findings agree in all important details with similar studies reported by Sayard and Harvey, and Lear and Harvey.

In my opinion, the work shows conclusively that defects in the dura will heal without the formation of adhesions in a very short period of time, provided the underlying arachnoid has not been injured. On the other hand, if the arachnoid has been injured, adhesions will form, regardless.

Too often, however, we see the mistake being made of covering these dural defects with facial transplants, or some other foreign material, which certainly is unnecessary and which, in my opinion, will do nothing more than increase the adhesions.

Frederick Leet Reichert, M.D. (Stanford University Hospital, San Francisco).—This experimental study of Doctors Glaser and Thienes confirms the clinical observations of neurosurgeons that, whether a portion of dura is excised or replaced without suture, the resultant gap is readily and completely closed by tissue which resembles dura and officiates as dura. This applies only where the pia arachnoid is intact.

In the clinical application of this experimental study, one need not be apprehensive about replacing a dural defect if overlying muscle is available; but if muscle cannot be used, a fascial graft or the prepared membrane will form a new dura. Again, this applies in cases in which the pia arachnoid is intact. Where the pia arachnoid is absent from any cause, one prefers to cover this pial defect by a plastic procedure with the patient's dura, leaving a dural defect over the intact pia arachnoid.

Howard W. Fleming, M.D. (384 Post Street, San Francisco).—Doctors Glaser and Thienes's clinical and experimental studies give further substantiation to the popularly accepted theories regarding the healing processes of brain and dural tissues. The facts that dural defects repair themselves spontaneously, and that adhesions do not form if the arachnoid is uninjured, are reassuring.

In the past, surgeons often went to great extremes to effect a complete closure of the dura following operation. This, in most cases, is no longer considered necessary. There are circumstances where the use of a dural graft may be advantageous.

It is advisable to debride and repair penetrating wounds of the brain. If the patient is cared for soon after injury, a careful debridement will lessen the possibility of infection and possibly reduce the morbidity. A snug graft in the dura will minimize the contusion to the brain and prevent a fungus should a marked increase of intracranial pressure develop as a late complication. A careful repair of the dura will also allow the replacement of small fragments of bone to fill the skull defect that could not otherwise be utilized.

In the treatment of post-traumatic epilepsy, excision of a cortical scar and the overlying dura is often necessary. Repair of the dural defect is not essential, but probably advisable. Occasionally, false meningoceles develop in cases where there is a loss of bone over the dural defect.

The kind of material to be used in dural grafts depends largely upon the past experiences and the preferences of the individual surgeon. Many prefer autoplastic substances, such as temporal fascia or fascia lata, on the theory that there is less foreign-body reaction than when heteroplastic substances are used. The author's conclusion in this paper would seem to negate this idea.

Probably careful handling of tissues and hemostasis are more important than the type of material used to fill a dural defect.

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TRICHINOSIS*

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Discussion *by John J. Miller, M.D., San Francisco; R. D. Friedlander, M.D., San Francisco; E. M. Butt, M.D., Los Angeles.*

THE Mosaic code, of some three thousand years ago, forbade the use of pork: "And the swine is unclean to you. Of their flesh shall ye not eat, and their carcass shall ye not touch."[1] Some believe that it was forbidden because the hog had been worshiped by certain heathen tribes; but modern interpreters[2] of this code maintain that Moses had noticed a peculiar train of symptoms in people who had partaken of pork, and thus condemned its use as food. For thirty centuries the Jews were ridiculed for abstaining from pork. During this time no one heard of trichinosis and, as far as is known, no one, until 1835, saw trichinella. In February of that year James Paget, then a medical student at St. Bartholomew's Hospital, London, "was dissecting the muscles of a subject, when his scalpel became quickly and repeatedly blunt."[3] He saw numerous small calcareous specks in the muscles. There was no microscope available at the hospital, but Robert Brown, the botanist, had a simple one at the British Museum through which Paget saw a worm within a capsule. He made careful sketches of the parasite, and prepared a report of his discovery for the *London Medical Gazette*;

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but it was never printed, although the manuscript may still be seen at the College of Surgeons. A specimen from Paget's subject was submitted to Richard Owen of the College of Surgeons, who named the parasite Trichina spiralis, and published his findings. The name was later changed to Trichinella spiralis.

Dr. Henry Bowditch [4] of Boston, in 1842, reported the first case of trichinosis in America in a young man who died from a malignant growth. Joseph Leidy [5] of Philadelphia, in 1847, demonstrated the parasite in pork. It was Zenker [6] of Dresden, who, in 1860, described clinical trichinosis. He established the connection of the parasite, which he saw in the muscles of a patient, with an illness clinically regarded as typhoid fever. He ascertained that the patient had eaten of flesh from a certain pig that had caused serious illness in everyone who had eaten it, and finally pointed out the parasites in ham and sausage from the pig in question. Within five years the people of Prussia and Saxony were in a state of panic because of fear of the disease during terrible epidemics. The German Government then instituted a method of examining pork microscopically, which is still in use. It consisted in pressing bits of muscle between glass plates and examining it, under the microscope, for the parasites. The infected animals were condemned for human consumption. Stiles [7] stated that the trichina inspection force in Prussia in 1895 was almost as large as the entire regular army of the United States of that year (27,089). Such a system gave a false sense of security, and pork was still consumed raw with dire results.

There is no doubt that rats harbor the trichinella. They have long been incriminated as the chief source of hog infection; but Spink and Augustine [8] are of the opinion that trichinosis in hogs is usually the result of their ingesting trichinous pork either in garbage or in the offal at times of slaughter. They believe that the infection in rats has its origin in trichinous pork scraps, and that it may be transmitted from rat to rat through cannibalistic habits, but that its return to swine through rats seldom occurs.

INCIDENCE: REPORTS IN THE LITERATURE

Hundreds of cases of trichinosis [9,10] have been recorded in American literature since Bowditch described his findings in 1842. While it is not considered to be so common as many infectious diseases, it does occur far more frequently than the published case reports and vital statistics indicate. Recent statistical studies, based on actually finding the parasites, show that trichinosis is a common disease in this country, and that the majority of cases are of such a mild form that they often pass unrecognized. In 1931 Queen,[11] by artificial digestion of fifty grams of diaphragm from 344 consecutive autopsies in Rochester, New York, found 17.5 per cent contained Trichinella spiralis. None of these cases gave a history of trichinosis, although some gave a vague "rheumatic" history. In a second series of fifty-eight cases in Boston, Queen found 27.6 per cent positive. Riley and Scheifley,[12] in a study of the diaphragms of 117 cadavers in Minneapolis in 1934, found 17.1 per cent positive for trichinella by pressing the muscle between glass slides. Hinman,[13] in 1936, examined ten grams of diaphragm, by the digestion method, from two hundred autopsies in New Orleans, and found only 3.5 per cent positive. Undoubtedly, he would have found a higher percentage had he used the fifty-gram quantities digested by Queen. Hall and Collins [14] reported 13.67 per cent of three hundred human diaphragms in Washington, D. C., positive for trichinella, using combined digestion and microscopic methods.

INCIDENCE IN SAN FRANCISCO

Recently we [15] reported that 24 per cent of the diaphragms from two hundred autopsies in San Francisco were positive for trichinella, using fifty-gram quantities by the digestion method. The diaphragms from an additional twenty-five new-born infants gave negative results. Living larvae were found in all the positive cases in San Francisco, but the number was usually small, being less than twenty to each fifty grams of muscle in 79 per cent of the cases. None of the clinical records of the positive cases revealed a definite history of trichinosis. Many of the case histories recorded "rheumatic" or "muscular" or joint "pains," "gastro-intestinal upsets" and the like, but these were as plentiful in the negative as in the positive cases. The results of these studies in six large, widely separated cities indicate that the actual incidence of trichinosis in the United States is rather high—averaging 15.6 per cent, or one in every six individuals.

Vital statistics of the Department of Health of San Francisco for the years 1931 to 1935 show a reported incidence of trichinosis, ranging from 0.0016 to 0.0044 per cent of the total population for each year. Those for the State of California, for the years 1932 to 1936, range from 0.0014 to 0.0006 per cent. A study of the sources of infection in 311 cases of trichinosis in California shows that 50 per cent were caused by the eating of salami or mettwurst sausages. The striking discrepancy between the number of cases of trichinosis reported, and the number of positive cases found at autopsy, demonstrates that the milder forms and sporadic cases of the disease usually pass unrecognized.

LIFE CYCLE OF TRICHINELLA SPIRALIS

Knowledge of the life history of the trichinella and the pathology of the disease is essential to an understanding of the symptomatology of trichinosis. Man is an accidental host to the parasite when he ingests infected meat. Pork is the usual offender; but a small epidemic due to bear meat [16] has been reported in this State.

Digestive juices liberate the encysted larvae, which pass into the upper intestine. In the course of two or three days they mature, copulate and, as early as the fourth day, the females, having burrowed into the mucosa, start bearing their young into the lymph spaces. During several weeks the

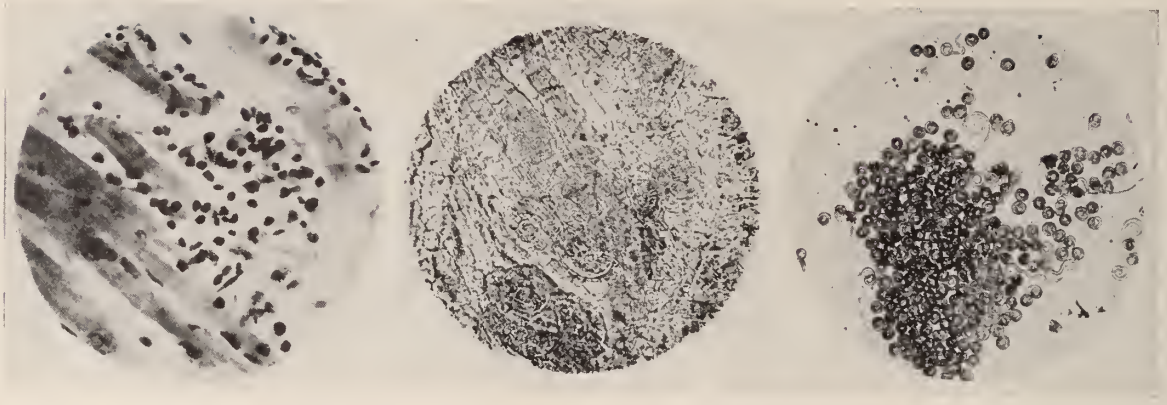


Fig. 1 Fig. 2 Fig. 3

Fig. 1.—Photomicrograph of cardiac muscle, showing necrotic muscle-fibers infiltrated by leucocytes, but no trichinella larvae. (X450).

Fig. 2.—Photomicrograph of sausage pressed then between glass slides, showing many encysted trichinella. (X40).

Fig. 3.—Photomicrograph of living trichinella larvae in the sediment of a digested human diaphragm. (X25).

female ejects a total of 1,000 to 1,500 actively motile young, which migrate and are carried by the lymphatics into the general circulation. The entire body is flooded with enormous numbers of embryos, which increase rapidly in size to almost ten times their original length. Many penetrate the skeletal muscles, become surrounded by a capsule of connective tissue and, in the course of time, often calcify, but may remain alive for many years. Larvae have been found in almost every tissue, fluid, and excretion of the body, but those which do not enter voluntary muscles usually die rapidly.

FACTORS CONCERNED IN THE LOCALIZATION OF TRICHINELLA LARVAE

It has long been known that the circulating trichinella invade such muscles as those of the diaphragm, tongue, larynx, and eye, the masseter and intercostal muscles, more than others. This has been explained by the fact that these are more active than other muscles. However, Berger and Stähelin [17] could demonstrate no quantitative relationship between the activity of a muscle and the number of trichinella it contained, using one paralyzed and one normal leg of animals infected experimentally.

Scheifley [18] investigated the rôle of increased blood flow in localization of the larvae by the removal of the lumbar sympathetic chain and ganglions from one side of dogs. Subsequent infection with trichinella revealed no significant change in localization of the larvae between the normal limbs and those with increased blood flow.

Lewis [19] found that the muscles favored by trichinella contained far less glycogen than those which are relatively spared. The diaphragm of normal guinea pigs contains only 7.2 milligrams per cent of glycogen, the masseter muscles 16.1, while those of the forelegs contain 488.1. He depleted the glycogen content of some of the animals by insulin, and administered large quantities of dextrose to others and infected all with trichinella. Dextrose lessened the migration of the parasites into the muscle, while insulin favored it. This is an encouraging step toward clarifying the question of specificity of localization of trichinella.

PATHOLOGIC CHANGES

The changes in the muscle during trichinous invasion are summarized from Sobel.[20] About the eighth to tenth day of the infection, embryos are found in the skeletal muscles, their long axis parallel to that of the muscle fiber. The fibers lose their striations and assume a finely granular appearance. With eosin-hematoxylin stain, the granules are a blue-violet color instead of the pink of normal muscle. This basophilic degeneration starts near the parasite and extends along most of the length of the muscle fiber. The trichinella curls up within the fiber, and the latter swells to two or three times its normal thickness. The muscle nuclei, normally close to the sarcolemma, increase in number and size, and move centrally about the parasite, become pale-staining and eventually degenerate. The granular degenerated muscle fiber assumes a more homogeneous compact appearance, forming a well-circumscribed elliptical mantle about the coiled worm. An interstitial myositis accompanies these changes from the beginning with infiltration of polymorphonuclears, eosinophils, and lymphocytes. The mesenchymal granulation tissue encircles the parasite with connective tissue, which later becomes hyalinized collagen of considerable thickness. Calcification may begin as early as the fifth month.

Trichinous myocarditis is not a specific picture. There is an active focal cellular infiltration of the myocardium, with lymphocytes, eosinophils, and polymorphonuclears, with necrosis and fragmentation of the muscle fibers apparently caused by the migrating larvae. Figure 1 is a photomicrograph of the cardiac muscle of a woman of sixty-four, who succumbed to trichinosis during the third week of her illness. The eosinophil count reached 39.5 per cent during the second week. Encysted larvae are rarely, if ever, found in the heart muscle. We have examined microscopically the hearts of two patients dead of trichinosis, and hearts of many rats with skeletal muscles peppered with encysted larvae, but have never encountered one encysted in the heart. The hearts of fifteen humans with encysted trichinella in their diaphragms at autopsy

failed to yield a single larvae by the digestion-concentration method.[15]

The meninges of patients exhibiting neurological manifestations may show marked infiltration with lymphocytes, plasma cells, fibroblasts, macrophages, and masses of eosinophils surrounding embryonic trichinella.[21] The brain itself may show granulomatous nodules, with or without parasites, and perivascular infiltrations of polymorphonuclears, lymphocytes, plasma cells, gitter cells, and fibroblasts.[22]

SYMPTOMATOLOGY

The symptomatology of the usual form of trichinosis may be closely correlated with the life history of the parasite. The maturation of the worms in the intestines corresponds to the gastro-intestinal upsets, nausea, vomiting, diarrhea, colic, and fever in the early stage of trichinosis. The period of dissemination of the embryos is marked by muscle aches, difficult and painful mastication, speech and respiration, petechial hemorrhages, edema, and eosinophilia. Spink and Augustine,[9] in an analysis of thirty-five cases of trichinosis, call attention to the fact that many do not exhibit a sufficient number of these symptoms to be readily diagnosed.

Trichinosis is comparable with any generalized bacterial infection. The chief difference is that the embryos of the trichinella are much larger than bacteria. The lesions produced are essentially a combination of toxic manifestations and embolic phenomena.

Myocarditis is one of the most serious, and not so uncommon complications of trichinosis.[23] It is frequent in severe infections, and is seen usually in patients dying in the fourth to eighth week of the disease. Cheney [24] has called attention to the occurrence of extreme hypotension in trichinosis.

It is not unusual to observe neurological manifestations in trichinosis, since the embryos invade the spinal fluid and brain. Most and Abeles [22] recently reviewed this subject, listing cases simulating meningitis, acute and chronic encephalitis, ocular disturbances, diplegia, deafness, and the syndrome of amyotrophic lateral sclerosis.

DIAGNOSIS

The diagnosis of a case of trichinosis should not be difficult, if it follows the common clinical course. A febrile disease with gastro-intestinal symptoms, muscle aches, and edema of the eyelids, calls for a blood count. Most cases of trichinosis will show a moderate leukocytosis, with an eosinophilia. The eosinophils usually increase rapidly, reaching a peak in the third or fourth week. We have also observed this repeatedly in experimental trichinosis in animals. The eosinophils in human trichinosis may mount to 75 to 90 per cent, although counts of 30 to 40 per cent are more frequently encountered.

The finding of the larvae in the body or body fluids of the patient makes the diagnosis certain. Examination of the stool for the parasites is often advised, but this procedure is rarely rewarded with success. Eosinophils have been found in the stools of trichinosis patients.[25] The laking of large quantities of blood or searching the sediment of spinal fluid is rarely satisfactory. Muscle biopsies, when obtainable, may prove satisfactory if the infestation is heavy, but there may be no parasites found in the excised tissue. Biopsy material or suspected meat is usually examined by one of three methods: (1) Portions of the material are pressed thin between glass slides and examined microscopically for encysted parasites. This is simple and rapid, and yields highly satisfactory results when the muscle is heavily infected. Figure 2 is a photomicrograph of a bit of sausage handled in this manner. This meat was responsible for an outbreak of trichinosis in Lower Lake, California. (2) Stained sections are essential for observing histologic changes in trichinous tissue; but unless the parasites are present in large numbers they may be missed if only a few slides are prepared. (3) The most satisfactory method in our hands for studying suspected material is by digesting the muscle with liberation and concentration of the larvae.[15] Figure 3 is a photomicrograph of the concentrated sediment from a human diaphragm.

SKIN AND SEROLOGIC TESTS

Within the last decade skin and serologic tests have been found of value in doubtful cases of trichinosis. Bachman [26] was the first to use trichinella antigen for diagnostic purposes. Augustine and Theiler [27] applied the test to human beings, and concluded that the skin test and precipitin reaction are of specific value in the diagnosis of trichinosis. Many other investigators have confirmed their findings. Recently, Spink [28] reported fifty-nine positive skin tests in sixty patients with trichinosis. The single negative reaction was elicited in a moribund patient, whose muscles at autopsy were shown to be heavily infiltrated with trichinella.

McCoy, Miller, and Friedlander [29] found that 92 per cent of thirty-six persons ill with trichinosis gave positive skin reactions, and Kaljus [30] reports 74 per cent of sixty-six cases were positive.

Skin Reactions.—Spink [28] describes two types of skin reactions to the antigen, an immediate and a delayed. The immediate type usually is not obtained until the second week of the infection. Within five to ten minutes after intradermal injection of the antigen a blanched wheal appears, sometimes with pseudopodia, but always with a surrounding zone of erythema. The reaction usually reaches its maximum within an hour, when it gradually subsides. The delayed type of skin reaction consists of an erythematous flare, following injection, which quickly subsides. Then, in twelve to twenty-four hours there is a red, slightly edematous, tender area from 1 to 3 centimeters in diameter, at the site of injection. This type, he believes, occurs early in the course of the disease, and later changes to the immediate type.

The precipitin test is performed by carefully layering 0.3 or 0.5 milliliter of a 1-100 dilution of trichinella antigen over a similar amount of serum in a small serological tube. The control consists of layering saline diluting fluid over the serum. Both tubes are incubated for an hour in a 37.5 degrees centigrade water bath. An opaque whitish ring at the junction of the antigen and serum indicates a positive test. Spink states that the precipitin test

usually becomes positive by the end of the fourth week.

We have recently investigated the skin reactions to trichinella antigen. The antigen is prepared in general according to the methods of Bachman, and others.[28,29] Adult white rats of the Wistar strain are fed about twenty free trichinella larvae per gram, by means of a stomach tube. Our strain of Trichinella spiralis was isolated from a human diaphragm, and is kept alive in the rat colony. After about five weeks the infected animals are sacrificed, skinned, eviscerated, and ground in a meat chopper. The meat is thoroughly digested in six to twelve hours by agitation in an aqueous solution of one per cent granular pepsin and 0.7 per cent hydrochloric acid in a 37.5 degree centigrade incubator. The lying larvae are thus freed from the meat and their capsules. The digest is passed through a twenty-mesh, then a sixty-mesh sieve, to remove undigested particles and bone, and placed in a large glass separatory funnel. The larvae settle to the bottom, are drawn off into a beaker and washed with tap water until the washings are clear and no débris is seen microscopically. The concentrate of larvae is dried rapidly in open Petri dishes within a vacuum desiccator in the incubator. It is important that this process be rapid to prevent bacterial growth, which would complicate the antigenic specificity. The larvae are then extracted with ether for twenty-four hours and again dried. This powder is the antigen. A 1-100 dilution of the powder is prepared in a small flask, using a buffered saline solution (0.5 per cent NaCl, 0.143 per cent Na_2HPO_4, 0.036 per cent KH_2PO_4 and 0.4 per cent phenol for preservative) with a pH of 7.1 This is permitted to extract for twenty-four hours at room temperature, then ground in a ball mill for another twenty-four hours. The resultant mixture is passed through a Seitz filter. The clear fluid, considered to be a 1-100 dilution of the antigen, is further diluted with the saline solution to make 1-500 and 1-10,000 dilutions of the original antigen, and placed in sterile vials with rubber stoppers of the type readily punctured by an hypodermic needle. Vials of the saline diluting fluid are prepared as controls.

The tests are made by the intradermal injection of 0.1 cubic centimeter of diluted antigen into the skin of one forearm with a similar injection of control solution into the other arm. The tuberculin type of syringes with short bevel, 26-gauge, hypodermic needles are best suited to these procedures. We have followed the methods of McCoy, Miller, and Friedlander, of routinely using the 1:10,000 dilution of the antigen for the first injection. If this is negative, a second test is made in about twenty-five minutes, using the 1:500 dilution. The immediate type of reaction is not considered positive unless the wheal is at least 7 millimeters in diameter and the zone of erythema 20 millimeters.

To date we have tested only five cases of clinically active trichinosis, ranging from the third to the sixth week of illness. These have all shown positive skin tests of the immediate type. One case of illness with a history, signs and symptoms of trichinosis and 16 per cent eosinophilia, on the tenth day gave a delayed type of reaction with a 25 millimeter tender area of erythema and edema. When tested on the thirtieth day, at which time the eosinophils had mounted to 54 per cent, the reaction was of the immediate type with a 10-millimeter wheal and 30-millimeter zone of erythema. A precipitin test on the serum from this patient on the thirtieth day of illness, using a 1-100 dilution of trichinella antigen, was also positive.

COMMENT

In view of our finding at autopsy that 24 per cent of the diaphragms in San Francisco contained trichinella with no history of trichinosis,[15] we are curious as to the number of persons living in this area with no history or symptoms of infection who show a sensitivity to the trichinella antigen. We have tested only sixty-three such individuals thus far, but have found 12.7 per cent of them give the immediate type of reaction and 11.9 per cent the delayed type. If all of the delayed types are specific reactions—and we are not convinced that they are —the total per cent of positive skin tests in this series is 24.6. This is unbelievably similar to the 24 per cent found at autopsy.

McCoy, Miller, and Friedlander found 18 per cent of 104 control individuals in Rochester, New York, and 6.5 per cent of forty-seven controls in San Francisco gave positive immediate reactions to the trichinella antigen. They state that delayed reactions were sometimes noted after twenty-four hours, "but their presence could not be correlated with the immediate reaction, and they have been disregarded."

Theiler, Augustine, and Spink[31] note that patients may show a positive skin reaction as long as seven years after infection with Trichinella spiralis. Thus, it is not possible by means of the skin test alone to distinguish between acute trichinous infections and those which occurred some years previously. We conclude from our few data that even the subclinical cases of trichinosis, which must greatly exceed the clinical ones, show sensitivity to the antigen.

TREATMENT

Patients with trichinosis should be treated as those with any other general febrile disease, by bed rest, adequate fluids, nourishment, and relief of pain. A preliminary purge has been recommended to remove such parasites as may still be free in the intestines. This may be of questionable value, since the females are usually buried in the mucosa.

A variety of agents have been employed in attempts to destroy the parasites in the body. Neoarsphenamin, antimony and potassium tartrate, acriflavin, rivanol, gentian violet, metaphen, Lugol's solution and sodium iodid were all found ineffective in experimental trichinosis by Miller, McCoy, and Bradford.[32] Miller, in a personal communication, states that further work indicates that there may be some value to the use of thymol, but that toluol and xylol are ineffective.

Since there are reports that the liberal use of alcoholic beverages, while ingesting trichinous-

meat, offers protection, we are now investigating this subject. Our results thus far indicate that such is really the case, but that the mechanism is one of interference with digestion and failure to liberate the larvae rather than a toxic action on the worm.

Blumer [33] questions the desirability of destroying, at one time, the enormous numbers of trichinella which are present in the body. It is possible, if an effective parasiticide were discovered, that the destruction en masse might result in a sudden flooding of the system with large quantities of toxic substances. Obviously, the larvae cannot be removed from the patient after they have left the intestinal tract and become encysted in the muscles. The administration of vitamin D [34] and calcium [35] has been advised to accelerate calcification of the capsule.

McCoy [36] has shown that immunity can be developed in rats, and others [37,38] report that while immune serum does not damage the parasites, it apparently neutralizes the toxemia. Salzer [39] was encouraged by his use of serum from recovered patients in treating clinical trichinosis.

COMMENT

It is readily seen that trichinosis is quite a common disease, but that the majority of cases are probably subclinical in type and are not diagnosed. The quantity of parasites ingested by the individual is probably the greatest factor in determining the clinical course. Its recognition depends on a critical history of the patient's illness as to possible sources of infection, examination of suspected meats, and a study of others partaking of the same foods. Patients with gastro-intestinal complaints, fever, vague muscle aches which persist, and an eosinophilia, should have a skin and precipitin test for trichinosis. Biopsy is of value if the parasites are present in sufficient numbers in the excised muscle, but it is an inconvenience to the patient, and frequently cannot be obtained. Skin and precipitin tests have been shown to be of high diagnostic value and may be performed at practically no inconvenience to the patient.

Since a certain number of individuals with no history of infestation show a positive skin test, it must be borne in mind that all evidence must be considered before making a diagnosis of trichinosis, especially in the sporadic cases, and that too much weight must not be attached to any one feature. The history, symptoms, signs, eosinophilia, skin and precipitin tests, must all be properly evaluated.

It is impossible to detect infected pork by practical methods of meat inspection. Therefore, it is necessary for the consumer to assume the responsibility of preventing trichinosis by either avoiding or thoroughly cooking all fresh pork.

SUMMARY

1. Trichinosis is a common disease, but the majority of cases are subclinical in type and are not diagnosed.

2. The incidence of trichinosis, as revealed by actually finding the parasites in autopsy material in six widely separated cities in the United States, averages 15.6 per cent.

3. Pathologic changes in skeletal muscle, heart muscle, meninges, and brain are briefly described.

4. Methods of diagnosis are reviewed. Eosinophilia is the simplest and one of the most reliable diagnostic clinical aids.

5. The technique for skin and precipitin tests, method of preparing trichinella antigen, and results of the tests are outlined.

6. The consumer must assume the responsibility of preventing trichinosis by thoroughly cooking all fresh pork.

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DISCUSSION

John J. Miller, M.D. (Stanford University Hospital, San Francisco).—Splinter hemorrhages under the nails, chemosis of the conjunctiva, and double vision are occasionally observed.

I cannot quite agree with Doctor McNaught's statement that direct examination of the blood and spinal fluid for parasites is rarely satisfactory. On two occasions I have found larvae in the blood. About 40 cubic centimeters of blood are taken, laked with two volumes of distilled water, and then centrifuged down. If any larvae are present, they are readily apparent in the sediment. This method is the quickest and simplest one for confirming the diagnosis. To my mind the procedure next in order is a lumbar puncture. I have seen larvae in the spinal fluid of five patients. Three or four minutes of centrifugation are sufficient. Obviously, the more spinal fluid obtained, the better the chance of finding larvae.

The skin test seems to be of definite value and should be used if antigen is available. While, as Doctor McNaught said, it is not possible by means of the skin test alone to distinguish between active and healed trichinosis, the skin hypersensitivity has a very definite tendency to decrease with time. Therefore, a positive reaction to a high dilution of antigen, 1:10,000 or higher, suggests active infection. We have seen skin reactions in acute trichinosis to a 1:1,000,000 dilution. The use of these dilutions is also important, when it is recalled that the skin test is not strictly specific. When McCoy tested ninety-two persons in southern Louisiana infected with Trichuris trichiura, he found 18 per cent positive to a 1:10,000 dilution, and 62 per cent positive to a 1:500 dilution. This group reaction is, of course, due to the close biological relationship between Trichinella spiralis and Trichuris trichiura.

Eosinophilia is also of the greatest aid in diagnosis. It should be remembered, however, that an absence of eosinophilia in a very sick patient does not rule out trichinosis. In two instances we have noted a drop in eosinophilia to less than 4 per cent within three days of death. Coincidentally, the skin reaction, which had been positive to a high dilution, became very weak shortly before exitus.

With the use of the above procedures a diagnosis can almost always be confirmed. I do not believe that a biopsy is often warranted. If a biopsy is finally done, however, the material should be digested as Doctor McNaught describes, rather than sectioned.

R. D. Friedlander, M.D. (384 Post Street, San Francisco).—I am glad, for two reasons, to be allowed the privilege of discussing Doctor McNaught's paper: First, because of my interest in trichiniasis, which has led me to follow carefully the literature on the subject for the past five years, so that I feel competent to state that Doctor McNaught's paper is not only the most comprehensive review of the subject to date, but it adds original findings that enhance to a considerable degree our present knowledge of trichiniasis. The second reason is that I should like to amplify several points that have been touched upon by Doctor McNaught.

Those acquainted with this problem know that my interest has been centered mainly in the intradermal test as a specific diagnostic measure. It was the original hope that the test, if positive, would give unequivocal evidence of an acute infestation by the larvae of Trichinella spiralis. We know now that, while there is no doubt about the specificity of the test, there may be some doubt about the acuteness of the infection when the test is positive, because it has been shown that individuals may exhibit a positive intradermal reaction as long as seven years after the first infection. Recent work by Spink, however, may help somewhat to clear up this problem. Spink has reported two types of intradermal reactions to trichinella antigen: an immediate, and a delayed. The immediate reaction usually does not occur until some time around the second week of illness, whereas the delayed reaction is said to occur earlier in the course of the disease. There has always been some doubt about the specificity of the delayed reaction; but if Spink's findings are corroborated by further work the intradermal test might serve not only as a diagnostic aid, but also as an indication of the stage of infection in new cases. What one might expect of the intradermal test, applied to an individual suffering from trichiniasis a second time, has not yet been determined. It is apparent that the allergic aspect of this problem must be of considerable importance. For the present, however, we must still rely upon a proper evaluation of "the history, symptoms, signs, eosinophilia, intradermal and precipitin tests" for the diagnosis of trichiniasis.

The diagnosis having been made, one is next interested in therapy. There is no specific remedy for trichiniasis as yet, so that prevention would seem to be of major importance, if members of the medical profession feel that this disease is on the increase. Doctor McNaught and, among others, Doctor Blumer of Yale Medical School, feel that the consumer must assume the responsibility of preventing trichiniasis by either avoiding or thoroughly cooking all pork. Doctor Blumer felt that the individuals responsible for the occurrence of the disease were not the meat dealers, but the consumers.

I cannot help but feel that this is a highly disputable opinion, particularly on the part of the profession. It seems all the more inconsistent, if one considers the fact that prevention of such diseases, which may be transmitted to the consumer in food products or by food handlers, has never been accomplished satisfactorily by the assumption of responsibility by the consumer. It is comparable to the statement that if the public consumes milk from tuberculous cows, it deserves to contract tuberculosis; or if the public consumes milk or water from typhoid-contaminated sources, it is responsible for the occurrence of typhoid fever. While these statements may be literally true, such has not been the stand of local or state health departments. The only justification for such a stand regarding trichiniasis is that, because it is not contagious, it could never assume large epidemic proportions; hence the attitude of *caveat emptor*.

This brings up the point that an important piece of work of considerable bearing on the epidemiologic aspect of this disease has been either overlooked or ignored. In 1932, Augustine and Theiler reported the results of precipitin and intradermal tests on a small number of swine infested with Trichinella spiralis. These tests were found to be positive in pigs, which, after slaughter, showed no larvae on extensive microscopic examination of muscle slips from the tongue, diaphragm, intercostal and masseter muscles. Yet after artificial digestion of the same muscular tissue, in the same manner as described by Doctor McNaught, large numbers of living trichinella larvae were obtained. The conclusion was that the precipitin and intradermal tests were more accurate than muscle examination. So far as I know, intradermal tests on swine have never been done

on a large scale to confirm this work. Nevertheless, if the findings of these workers should be definitely confirmed, then intradermal tests in trichinous pigs would be just as specific as tuberculin tests in tuberculous cows. The opinion that has been held in the past, that we must have trichiniasis because of the inability to detect infested swine, would then be tenable no longer.

E. M. Butt, M.D. (University of Southern California School of Medicine, Los Angeles).—Our attention has been drawn to the subject of trichinosis by the startling figures obtained by a few recent workers in determining the prevalence of trichina infestation in cadavers. These figures are from widely separated localities and, excepting the report from New Orleans, indicate an incidence of trichina infestation in well over 15 per cent of the cadavers examined. Yet, as McNaught has pointed out, the vital statistics of the State of California show a very low incidence of the disease. This discrepancy has been dismissed quickly with the conclusion that, clinically, the disease is rare, and that subclinical infestation is common. However, quantitative evaluation of infestations would indicate that such an inference is not true in a certain percentage of positive cases. It follows, therefore, that patients with trichinosis are not seen medically or that our training and diagnostic methods are faulty and require scrutiny. Aside from the clinical importance of trichinosis, there is a public health aspect of utmost interest.

Recently, we have completed the examination of 150 diaphragms by the digestion method. These specimens have been taken at random from our autopsy service. The total percentage of positive findings was 17.3 per cent. Further analysis of these figures revealed a higher percentage of infestation in females than in males. This is due to the high incidence of trichina in diaphragms of colored females, a figure which in our small series was close to 50 per cent. Thirty-seven per cent of the diaphragms from Mexicans and Negroes, both males and females, were positive for trichinae.

It is still too early to adequately evaluate the diagnostic importance of the skin test. The few clinical cases that we have seen have all given an immediate positive reaction to the antigen. However, there are reports in the literature that indicate that such is not always the case. Furthermore, positive skin tests have been obtained in individuals with Trichuris trichiura infestation. So far, little attention has centered around the trichina skin test in hyperergic patients. These and other aspects must be taken into account before the skin test can be considered reliable in the diagnosis of trichinosis.

Trichinosis is a subject of considerable clinical and public health importance. Doctor McNaught's admirable paper should help to create more interest in the subject.

SNAKE VENOM: ITS USE IN POSTOPERATIVE HEMORRHAGE OF THE EYE*

By W. F. Swett, M.D.
San Francisco

Discussion *by Warren D. Horner, M.D., San Francisco; Frederick C. Cordes, M.D., San Francisco.*

THE management of postoperative hemorrhage, following major procedures on the eye, is always difficult to control, and the usual procedures are notoriously ineffective. These cases have always been a source of worry, and in my effort to find something to control this situation I was encouraged by reports of Peck [1] (1931), McFarlande and Barnett [2] (1934), and Dack [3] (1935), in their use of moccasin venom in the treatment of hemorrhagic disease.

During the past year I have had several stubborn postoperative hemorrhage cases which were responsible in my using the snake venom therapy, in an effort to find a good postoperative treatment in this distressing complication.

MOCCASIN VENOM

The moccasin venom was prepared in a concentration of 1/3000, in a physiological saline solution with 1/10,000 merthiolate being added as a preservative. According to these authors, it was efficacious in functional uterine bleeding, epistaxis, and hematuria in the Henoch-Schönlein syndrome, in thrombocytopenic purpura, in multiple heredity telangiectasis, and in hemoptysis from bronchiectatic cavities. The more recent applications have shown that the venom is excellent as a coagulent in local intractible bleeding, and was found especially effective in cases of functional uterine bleeding and idiopathic nasal hemorrhages. This led to its being used preoperatively, in patients predisposed to excessive hemorrhage, with equally good results. Hemophitic blood, which normally clotted in twenty to forty-five minutes, was clotted in seventeen seconds by a 1/10,000 dilution of venom, and has been used successfully in managing hemophiliac hemorrhages following dental extraction, tonsillectomy, epistaxis, and oozing from abdominal wounds.

In giving the venom, ecchymosis may develop at the site of injection in the first twenty-four hours, and most patients develop a reaction of hypersensitivity in approximately ten to fourteen days; however, the reaction is always local, and characterized by a hot, tender swelling at the point of injection only. No general reaction may be feared. In the six cases that I have used it on up to date, I have had no reaction whatever, either local or general.

The continuous oozing of blood from the iris or the wound into the anterior chamber, following cataract extractions, prolongs the healing and in many instances results in the failure of the wound to close, or even a painful eye with rupture of the wound and prolonged seepage from the anterior chamber.

In the first case, hemorrhage occurred the first day following operation and continued to ooze in spite of all treatment for ten days. I decided to use the moccasin venom put out by Lederle, and was very pleasantly surprised when the oozing stopped immediately after the first injection of .4 cubic centimeter. As soon as the hemorrhage was checked, the blood disappeared rapidly from the anterior chamber and the wound was closed completely four days later. I have used it in four cases since with identical results. These results have been so satisfying that I have come to look upon the venom as indispensable in the control of postoperative hemorrhage. To date I have only administered it in those cases which showed a tendency to hemorrhage after operation, and found that .5 cubic centimeter given daily for one week has been sufficient. I feel that the ideal method of use would be to give these injections previous to operation to prevent the complications rather than to correct them. I have not gone into this phase of the subject because I first wanted to demonstrate to my satisfaction the action of the venom on actively hemorrhaging cases.

* Read before the Eye, Ear, Nose, and Throat Section of the California Medical Association at the sixty-sixth annual session, May 2–6, 1937.

In one case of a severe iridocyclitis, accompanied by hemorrhage in the anterior chamber, I gave .5 cubic centimeter subcutaneously and have found that it also stopped the bleeding in the face of a severe inflammation in which no operation had been performed.

IN CONCLUSION

I am convinced that the most important point in the use of venom in postoperative hemorrhage is to give it in large enough doses to rapidly control the bleeding, and as it is not continued long enough to produce sensitization, this point need not be feared. The patients tolerate .1 cubic centimeter daily up to fourteen days if necessary, without any untoward symptoms.

In two other cases I used a dosage of .1 cubic centimeter daily for four days without any signs of hypersensitivity or local reaction.

In this small series of six cases, I believe I have demonstrated that moccasin venom has a definite place in the control of postoperative bleeding, and also has possibilities as a prophylactic procedure which may be used in intra-ocular surgery, particularly in cases where we are suspicious of having postoperative bleeding.

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DISCUSSION

Warren D. Horner, M.D. (384 Post Street, San Francisco).—A snake swallows its food whole, and what could be handier for a snake than a hypodermic injection ready at all times to paralyze its prey and to assist in its digestion! This is precisely what a venomous snake has. The venom is secreted in glands homologous with the mammalian salivary parotid. It is led down to fangs which are either grooved or hollow and so placed as to pierce the thing bitten. The act of biting contracts the temporal muscle, which exerts pressure over the poison gland which forces the venom to the fangs.

The toxic action of venoms varies enormously among the different snakes.

A large group of venoms, such as those of the Indian cobra and Australian death adder, act like curare in paralyzing skeletal muscles, and death may take place from paralysis of the muscles of respiration.

Another group, chiefly of the viper family, causes death by peripheral circulatory failure.

A third group causes death by the rapid coagulation of the victim's blood, due to the presence of thrombin or kinase in the venom, which set off the clotting reaction.

Other venoms contain anticoagulating substances thought to be antikinase or antithrombin. Hence, venom from the cobra, Australian copperhead or death adder causes blood to become incoagulable, either *in vivo* or *in vitro*.

Since we are interested alone in coagulating effects, we will discuss this phase further.

As early as 1893 Martin pointed out that certain snake venoms caused intravascular clotting.

In 1903, Lamb found that citrated blood could be clotted by particular venoms.

McFarlane and Barnett,[1] in 1934, found that a 1:10,000 dilution of viper venom could be sterilized by a Birkefeld filter, was not toxic in this dilution, and had coagulating powers even in hemophilia. This dilution has been used ever since in St. Bartholomew's Hospital, London, particularly in dental extractions, tonsillectomies, oozing of viscera, such as kidney and liver, and prostatectomies.

In America, since 1931, Peck[2] has advocated the use of moccasin venom and, with Lederle, has given us a commercial supply.

Rosenfeld and Lenke (1935) have used venom of the Australian tiger snake as a hemostatic.

The exact rôle of viper venom in the process of blood coagulation has been studied.

As you remember, the clotting of normal blood follows this scheme: Prothrombin in the plasma, plus calcium salts in the plasma, plus thrombokinase or injured-tissue juice, yields thrombin, which reacts with fibrinogen in the plasma to form fibrin or clot.

Indian and Australian viper venoms contain substances which are the equivalent of a mixture of thrombokinase and calcium, which can generate thrombin and set off the clotting mechanism.

Peck and Rosenthal attribute the coagulating effect of moccasin venom either to some effect on the blood-vessel walls or on the clotting factor of the blood.

Snake venom for antihemorrhagic purposes has been given a successful trial both in London and America. Its use to prevent hemorrhage in the eye is, as far as I can determine, original with Doctor Swett, for I noted no other reference relative to its employment in ophthalmology.

There are many cases in eye surgery where the fear of bleeding or recurrence of bleeding literally haunts one. Furthermore, we have only feeble means to prevent hemorrhage, even when we fear it preoperatively. I have never felt confident that calcium or horse serum, or anything else for that matter, could be depended upon.

In snake venom we have a promising new reagent which is worthy of our trial, and we are indebted to Doctor Swett for bringing this remedy to our attention.

❦

Frederick C. Cordes, M. D. (384 Post Street, San Francisco).—Doctor Swett has called to our attention a therapeutic measure that has a definite place in our armamentarium. It offers a rapid and effective means of controlling hemorrhage in certain cases.

The control of hemorrhage comes briefly under three headings: (1) Measures to remedy any underlying constitutional cause, such as scurvy. (2) Steps to prevent the flow of blood from the bleeding vessel by the application of direct pressure, or substances that contract the vessels. (3) Consolidation of the blood.

It is primarily with the third that we are concerned in the discussion of snake venom. According to Huggett,[3] the main coagulants used in medicine may be listed in five physiological classes.

1. Thrombokinases, such as tissue or platelet extracts, preparations of brain tissue or cephalin itself.
2. Thrombin preparations.
3. Calcium variants, such as calcium salts or parathyroid extract.
4. Proteins. Foreign proteins, peptone, and the blood sera of animals have been used.
5. Physical means; carbon dioxid inhalations, extreme heat, and styptics.

The use of snake venom comes under the head of treatment with thrombins, as it has been shown that venom, particularly that of vipera russellii, contains a highly active thrombin. In addition to being a powerful coagulant, venom also produces a very strong clot. The rapidity of action is most dramatic, as Doctor Swett has stated. From the above it follows that in those cases where the bleeding results from an abnormality of the blood itself, one can expect help from the use of snake venom.

In addition to the type of case mentioned by Doctor Swett, the prophylactic use of snake venom suggests itself in those cases of apparently simple contusion of the eyeball that develop severe vitreous hemorrhages, three to five days after the injury.

I feel that this paper is of particular significance, as it is, to the best of my knowledge, the first report of the use of snake venom in ophthalmology, and one of a very few instances of the use of venom reported in the American literature.

1 McFarlane and Barnett: Lancet, 2:985, 1934.

2 Peck: Treatment, J. A. M. A., 105:413 (Aug.), 1935.

3 Huggett, A.: Proc. Roy. Soc. Med., Vol. 30, No. 5, p. 645, 1937.

BRUCELLOSIS OF THE MALE GENITALIA*

By Thomas I. Buckley, M.D.
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Discussion *by Morrell Vecki, M.D., San Francisco; Jay J. Crane, M.D., Los Angeles; Donald A. Charnock, M.D., Los Angeles.*

RECENT articles, published by those interested in the epidemiology of brucellosis, stress that the disease is on the increase throughout the United States.[1] For the country as a whole, the number of reported cases has steadily risen from 24 in 1925 to 1,897 in 1935, and in California 15 cases in 1927 to 148 in 1936. The true incidence is evidently higher, as these statistics were compiled from cases whose agglutination tests were positive; whereas patients have recovered spontaneously before the diagnosis was made and, therefore, have not been reported. With increasing frequency it is more than likely that genito-urinary tract complications, as a result of brucellosis, will be more numerous.

It will be the aim in this paper to call to your attention the various aspects of the disease, and emphasizing, where possible, involvement of the genito-urinary system. The care of the patient affected with this ailment is usually in the hands of the internist, except when surgical complications arise. It may be a localized genito-urinary system lesion, however, for which the patient first consults a urologist. For this reason, I believe, it is well that we have a general knowledge of the disease.

HISTORICAL

For years authors have used varied names in classifying this disease, the most common being Mediterranean fever, Malta fever, and undulant fever. Recently, the term "brucellosis" has been adopted both in this country and abroad, and this newer terminology will clarify discussions on the subject.

In 1885, David Bruce described the disease while on the Island of Malta and was the first to isolate the causative organism, Micrococcus melitensis. He also showed that 50 per cent of the goats on the island were infected, and proved that the disease was transmitted through their milk. Ten years later, Bangs, a Danish veterinarian, discovered the organism Bacillus abortus, which causes contagious abortion in cows. In 1917, Alice Evans demonstrated that Bacillus abortus and Micrococcus melitensis had similar cultural, morphological, and serological characteristics. From the work of the above three, the general term of brucella or brucella infection was applied to the whole group.

In 1924, Keefer reported the first proved case of human infection with the Brucella suis. Since then the disease has been in all parts of the country: geographically, the bovine type is somewhat uniformly distributed, while the porcine and caprine types are largely confined to specific localities. The morbidity rate is much higher in those dealing with livestock, fresh meats, and raw dairy products.

CLINICAL FEATURES

After an incubation period of one to two weeks, the first symptoms are usually those of an acute infectious disease, namely, fever, chill, profuse sweating, general muscular aches, arthritic pains, abdominal discomfort, nausea with occasional vomiting, and anorexia with loss of weight and strength. The patient has an appearance of well-being not consistent with his high fluctuations of temperature. Recovery from one to two months is the rule; however, one or more relapses is not uncommon. The mortality rate is 2 to 3 per cent, usually due to localized complications with toxemia.[2]

PHYSICAL SIGNS

Other than fever, there is often no other symptom early in the disease. Later, the spleen is frequently enlarged, and there is progressive anemia and loss of weight.[3] Doctors Hardy, Jordon, and Barts, in a paper published in the *Journal of the American Medical Association* for August, 1936, emphasize the occurrence of localized brucella infections in animals, and it is not unexpected that the same suppurative lesions occur in the human. In their article, based on 705 cases in the State of Iowa, they enumerate the more common lesions from which the brucella has been isolated, such as chronic cholecystitis, meningitis, arthritis, and lymphadenitis. Cases with initial symptoms of cystitis and renal tuberculosis have been diagnosed as brucellosis through isolation of the organism from the urine and positive agglutination tests.

LABORATORY DIAGNOSIS

The agglutination test is of the greatest value. At times, especially in the chronic cases, it may become negative, but here the skin test with brucella antigen has been found to be positive when the blood agglutination has been negative, or in lower dilutions.[4] Positive skin reactions in those working with the organisms, as laboratory technicians or veterinarians, without symptoms only indicates exposure to the disease. Recovery of the organism from the blood is positive proof, but cultures are frequently negative in acute cases. Special media for blood cultures can usually be supplied from the Hooper Foundation, where much of the work is in progress.[6] In the chronic supperative lesions the organism can be identified by serological tests after being grown on the special medias.[5]

In the blood picture there is a leukocytosis at the onset, but leukopenia with anemia soon occurs.

TREATMENT

Hardy, Jordon, and Barts, the men quoted early in the paper, summarize their views on treatment by stating that, as yet, conclusive evidence as to the value of specific therapy has not been obtained. Some feel that the brucella vaccine is of value, although it does cause a local and general reaction.

Many times the illness has an abrupt termination without any specific form of therapy being used except bed rest and supportive treatment. Complications and sequelae naturally must be handled as any other surgical condition, whether

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Read before the Urology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

it be in skin, bone, chest, or genito-urinary system. I have not seen or read in the literature of any suppurative lesions in the genito-urinary system in the human which needed surgery, but have seen them in the testicles of animals, causing complete destruction by abscesses. In the case I am to report, involving the testicle and epididymis of a young university student, the infection subsided without any surgery being necessary.

REPORT OF CASE

The patient, a nineteen-year-old university student, entered the Cowell Memorial Hospital (University of California Campus) March 18, 1935, complaining of a very painful left testicle associated with nausea and vomiting. He attributed the cause to football practice two days previously, but there was no definite knowledge as to any injury. On questioning, no further information of note was obtained.

Physical Examination.—Although the patient's temperature was 102 degrees Fahrenheit when he entered, he did not feel ill except for his complaint of pain in the left testicle. The physical examination, other than the left testicle and epididymis and chronically infected tonsils, was practically negative. There was no urethral discharge nor a history of ever having a discharge. The left testicle was enlarged and painful to gentle palpation. The globus minor appeared to be enlarged, soft and tender. The cord was normal in size, not nodular, and not tender.

Laboratory Findings.—Urine, normal; tuberculin, negative; Wassermann, not done; blood culture, negative; blood counts, first on March 18, 1935 (day of entry), white blood cells 14,000, polymorphonuclears 68 per cent, mononuclears 31 per cent; second on March 22, 1935, white blood cells 6,600, polynuclears 38 per cent, mononuclears 60 per cent, eosinophils 2 per cent.

This count demonstrates the fact that at the onset of the disease there is a leukocytosis, followed rapidly by a leukopenia with an increase in the monocytes. On March 26, 1935, the blood that had been sent to the State Laboratory on the Berkeley Campus, reported negative for tularemia, typhoid, paratyphoid A and B, but a positive agglutination for brucellosis of 1 :1280.

Course.—The boy did not appear ill, but his temperature fluctuated between 102 and 101 degrees Fahrenheit for six days, and on the seventh day it was 99 degrees Fahrenheit, and from then on until his discharge, was normal. The testicle and epididymis were supported by a Bellevue bridge and ice packs applied, but they remained swollen and painful for eight days, after which the swelling gradually subsided. He was discharged from the hospital fifteen days after entry with normal temperature and very little swelling or pain in the left testicle and epididymis.

Interval History.—The patient was well until October 12, 1935, when he again entered the hospital with symptoms of catarrhal jaundice. There was nausea and vomiting, abdominal cramps, and jaundice, the icterus index reaching 273. There was no fever at any time during his stay in the hospital. The agglutination for brucellosis was positive in the dilution of 1 : 640. Biliary drainage was instituted and bile was to be cultured for the brucella organism, but unfortunately the specimen was destroyed accidentally. Melitensis and abortus vaccine was given intramuscularly (.25 cubic centimeter); however, it was administered thirty-eight days after entry, and the symptoms as well as the jaundice had subsided. Two more injections of the vaccine were given after his discharge, none of them causing any local or general reaction.

COMMENT

On March 18, 1937, two years after the illness, the agglutination titer was 1 to 100. Here we have a case of brucellosis with indications that it had localized in the testicle and epididymis, to be followed ten months later by the symptoms of gallbladder disease. The question arises, "Where did this young man contract the disease?" His father owns a cattle ranch in California, but the student had not been home for nine months. It is possible that his was a case of chronic brucellosis, with very late localizing symptoms. At the time of his first entry into the hospital in March, 1935, he was working in a local restaurant where fresh livestock and dairy products were being handled. No other cases were reported from this source, nor were there any other cases reported in the county at this time, so we must say that the source of the infection was not determined.

BRUCELLOSIS IN GOATS

Through the courtesy of Dr. C. M. Haring of the Veterinary Science Department of the University of California at Berkeley, I had the opportunity of observing a goat infected with brucellosis, which had localized in the left testicle and epididymis. On autopsy, no significant lesions were found, except the following:

The left tunica vaginalis, which showed fibrous thickening, contained a moderate-sized hydrocele. The left testis was enlarged to 8 by 5 centimeters in diameter, and on cut section showed numerous necrotic and hemorrhagic areas 1 to 5 millimeters in diameter. Some were discrete and others confluent. The epididymis on cut section also showed these marked discrete necrotic areas measuring 1 to 6 millimeters, resembling caseous necrosis seen in tuberculosis.

Brucella abortus was isolated in pure culture from the hydrocele fluid, and from the parenchyma of the testicle and epididymis.

The microscopic pathology was described by Dr. Paul Michael of Oakland, whose report follows:

Pathological Report.—Microscopic examination of the testicle shows practically a complete loss of normal markings. The glandular elements appear to be replaced by inflammatory granulation tissue. There is a diffuse background of large, oval and polyhedral-shaped epithelioid cells. These cells have clear-cut membrane, pale azure cytoplasm and eccentric nuclei, with vesicular nucleoli. Interspersed through this background are clear spindle-shaped fibroblasts and some well-defined, mature fibrous tissue fibers. In addition to these cells there are numerous, scattered mononuclear cells, oval and round in shape, containing deeply stained nuclei and distinctly basophilic cytoplasm. There are also a few scattered lymphoid cells, large plasma cells, and a few polymorphonuclear leukocytes. In addition to this diffuse background there are small tuberculoid aggregations, composed of densely packed round cells, fibroblasts and epithelioid cells, with some areas of central caseous necrosis. There is an occasional giant cell observed.

Sections through the epididymis show a marked interstitial fibrosis in the stroma with distortion of the glandular elements. Most of the ducts show compression, but a few are the seat of ectasia. The stroma is rich in both proliferative fibroblasts and mature fibrous tissue. The blood vessels show some endo-arteritis, and surrounding the glands are scattered round cells and plasma cells.

SUMMARY

1. Brucellosis, a disease contracted through dairy products and livestock, is on the increase throughout the United States, and we, as physicians, should have a general knowledge of its symptoms and diagnosis.

2. A case history is presented giving the symptoms and clinical course of brucella infection, which had localized in the genital system.

3. The gross and microscopic picture of the lesions produced in animals involving the testicles and epididymis are shown.

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DISCUSSION

Morrell Vecki, M.D. (450 Sutter Street, San Francisco).—Doctor Buckley has introduced a new etiologic factor, brucellosis, which has rarely been recognized and isolated in diseases of the genital tract in man. He has given an excellent résumé of the history and clinical manifestations of the disease.

In 1917, shortly after Alice Evans demonstrated that Bacillus abortus and Bacillus melitensis had similar cultural, morphologic and serologic characteristics, experimental work was begun at the Hooper Foundation in San Francisco by Meyer, Fleischner, and Shaw. It was soon demonstrated that Bacillus abortus was always present in certified milk produced in the San Francisco Bay region. Incidentally, the name "Brucella," honoring Bruce, who discovered the Malta fever organism, was proposed by Meyer and Shaw.

In 1920, while studying for my master's degree, it became my privilege to work with these investigators. Our particular problem at that time was to find out if Bacillus abortus could produce a disease similar in the monkey to that produced by Bacillus melitensis, or Malta fever germ, since it had been reported that, in the monkey, a disease was produced similar to that seen in man.

By injecting monkeys and feeding them with large doses of organisms, agglutinins were developed fairly rapidly. At postmortem examination it was possible to recover the organisms from the spleen, lymph nodes, and liver. We have no record of having recovered the organism, or having produced the disease in any part of the genital tract of these animals.

Recently, I came upon an article by Simpson, who had studied ninety cases of brucellosis in and about Dayton, Ohio. Evidence of orchitis, epididymitis, prostatitis, and seminal vesiculitis, was found in three of the patients, all being raw-milk consumers. In one case the organism was recovered from a draining sinus tract, which extended from the globus major through the scrotal wall.

In conclusion, I can state that Doctor Buckley's case report will set an example for us to be on the alert to investigate any obscure genital lesion for brucella infection.

❦

Jay J. Crane, M.D. (1921 Wilshire Boulevard, Los Angeles).—A proved case of brucella infection of the testicle and epididymis in a human has not yet, so far as I know, ever been reported. I can see no reason why the infection should not involve these structures, because other tissues are not uncommonly involved.

Doctor Buckley's interesting case report comes closer to being a proved case than has as yet reached the literature. However, the history, physical findings and course of the infection, as described, are in no way pathognomonic of a brucella infection of these structures, and without a positive culture having been obtained from the testicle and epididymis, one cannot differentiate with certainty between a nonspecific infection and a brucella infection. I, therefore, do not consider Doctor Buckley's diagnosis as positive; yet it is certainly very suggestive.

Doctor Buckley has brought to our attention the great possibility that many of the so-called nonspecific epididymitis cases may be due to brucella, which is especially true in those patients who have recurrent attacks of epididymitis; and I believe this latter group should all have an agglutination test for brucellosis, in view of the fact that the disease is on the increase.

❦

Donald A. Charnock, M.D. (727 West Seventh Street, Los Angeles).—Brucellosis is fairly common in California, especially in the agrarian districts. In reviewing the disorder, attention is directed to the numerous complications. The disease is not rare in Southern California, but there is no record of urologic complications in our largest hospital.

The description of the physical findings and the clinical course is well brought out. It is an established fact that the agglutination test remains positive for a long period of time. This test must be carefully evaluated in making a diagnosis of brucellosis.

While there have been no cases of orchitis and epididymitis reported in the American literature within the past few years, four cases are recorded in the foreign literature. Three of these cases originated in Italy and one in France.[1]

Dr. Harold J. Harris of Westport, New York, calls attention to the complication and states that it may be present in one per cent of the cases.[2]

In urologic practice we are often called upon to help identify cases of persistent fever. These cases should all be checked for brucellosis. Recently, I was called to see a case of persistent fever. Here a few pus cells in the urine directed attention to the urinary tract. Examination revealed a normal upper tract. A prostatitis accounted for the lower-tract infection. The agglutination test for brucellosis was strongly positive. The temperature returned to normal, and all of the symptoms cleared after the administration of a vaccine obtained from the Hooper Foundation.

MEDIOLATERAL EPISIOTOMY*

By George D. Huff, M.D.
San Diego

Discussion *by A. M. McCausland, M. D., Los Angeles; Hall G. Holder, M. D., San Diego; Donald G. Tollefson, M. D., Los Angeles.*

An episiotomy is the substitution of a clean, straight, carefully made cut in a known and safe place for jagged, irregular tears in unsafe and unknown places. This operation is now the most neglected obstetrical procedure. It should be used in 97 per cent of full-term primipara. The operation should be performed after the pelvic floor has been moderately stretched by the presenting part, but before damage has occurred.

TECHNIQUE

The mediolateral is used exclusively in this series. The incision is made with a sharp scalpel following the injection of one-half per cent novocain. The needle is inserted in the median raphe at the vaginal entrance and carried mediolaterally immediately under the skin for a distance of three inches. Ten cubic centimeters of novocain are injected in this area. The needle point is now drawn back to the median raphe and carried in again at the same angle, and for the same distance; but just above the urogenital septum and levator ani muscle.

1 Presti and Seminerio: Rinasc. med., 11:621-623 (Oct. 31), 1934. Benincasa: Rinasc. med. 14:260-263 (April 30), 1937. Farjot and Dumond: Soc. de méd. mil. Franc., Bull. mens. 29:290-293 (Nov.), 1935. Garcia and Ruiz: Policlinico, 42: 1912-1921 (Sept. 30), 1935.

2 Harris: J. A. M. A., 109:1300 (Oct. 16), 1937.

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

Fifteen cubic centimeters of novocain are required for this area. Three minutes should elapse before the incision is made, to allow the novocain to spread through the tissues to be anesthetized. With the first finger of the left hand in the vagina, pulling the pelvic floor toward the operator, it is easy to locate, with the aid of the thumb, the thin round edge of the urogenital septum, and the thicker and deeper edge of the levator ani muscle. The operator now knows the tissues to be severed, their exact location, their thickness and the depth of the incision to be made in each structure. The finger remains in the vagina until the operation has been completed. The incision is started in the median raphe at the vaginal opening, carried mediolaterally and through skin and subcutaneous tissue, exposing the urogenital septum. The urogenital septum, after being identified, is severed by the second stroke of the knife. The levator muscle and fascia cannot be seen and are incised in a similar manner. The outward pressure of the finger in the vagina will cause the cut edges of the severed tissues to separate, and at the same time the pressure will control bleeding. Finally, the incision is made along the vaginal floor for a distance of about two inches. Bleeding vessels should be clamped and tied as in any other operation. The dissection is now complete.

INFECTION

After the baby has been delivered, it is of the greatest importance to redrape the field of operation. Direct infection from the rectum must be avoided. Great care must be exercised to prevent the ends of the sutures from touching the rectum, or some contaminated area. Gloves should be changed before starting the repair.

REPAIR

The skin, subcutaneous tissue, urogenital septum, levator fascia, levator ani muscle, and the vaginal floor must be clearly recognized. The incision was started in the skin and carried inward, layer by layer, toward the vaginal floor. The repair is started in the vaginal floor and carried outward, layer by layer, until the skin has been closed. The incision is held open by a Gelpi retractor. Chromic catgut No. 2 is used exclusively. The apex of the vaginal floor incision is picked up with an Allis clamp. The suture is inserted and tied around the clamp to prevent bleeding from the angle. The suture is then carried, in a continuous manner, down to the mucocutaneous junction at the opening of the vagina. The rounded edges of the urogenital septum on each side of the incision are grasped by Allis clamps and pulled well up toward the symphysis, bringing all the severed structures into view. The first step in closing the urogenital septum and levator ani muscle is to place a suture just to one side of the deepest point of the incision in these structures, and be sure the suture passes through both layers of the urogenital septum, the levator fascia, and levator ani muscle. The suture must be passed through the same structures on the opposite side of the incision but, of course, in the reverse order. It is important not to allow this first deep suture to pass through the rectal wall, but to make sure it passes through both layers of the septum, levator ani fascia, and muscle on both sides of the incision. The Gelpi retractor is partly released and this suture is tied. Similar interrupted sutures are placed three-fourths of an inch apart, until the upper edges of the urogenital septum have been brought firmly together. The subcutaneous tissue is closed with a continuous suture. The skin is closed with a continuous subcuticular stitch, starting at the apex of the skin incision and ending at the mucocutaneous junction. This suture is tied to the one closing the vaginal floor, which leaves no sutures or knots exposed near the rectum.

RESULTS IN FOUR HUNDRED AND TWELVE PRIMIPARA*

Primipara studied	412
Severe infection, two	0.46%
Mild skin infection, twenty-six	6.3 %
Healed but followed by relaxation, thirteen	3.1 %
Hematoma, one	0.23%
Marked pain, two	0.46%
Satisfactory results	89.5 %
Vaginal dilatation before sexual relation could be resumed	35.0 %

CONCLUSIONS

1. This operation should be respected.
2. Good results can be obtained, and will soon be demanded by patients.
3. The mediolateral is one of choice.
4. A slow, deliberate, painless, and scientific operation can be done under local.
5. Each structure can and should be recognized before cutting.
6. A sharp scalpel should be used.
7. All bleeding should be controlled, as in any other operation.
8. The wound should be watched and treated by the doctor and not by the student nurse.
9. Patients have been pleased with this method.
10. A definite fee should be charged for this operation.

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DISCUSSION

A. M. McCausland, M. D. (3780 Wilshire Boulevard, Los Angeles).—The general use of analgesia today has resulted in increased elective low-forceps deliveries, with a corresponding increase in episiotomies in multiparae as well as in primiparae. In addition to the many other reasons and indications already discussed, may I point out that, if the episiotomy is done early, lacerations in the region of the urethra, clitoris, and vestibular bulbs may usually be prevented. Thus, hemorrhage in these locations, which is often difficult to control, is avoided and, still more important, scarring and adhesions about the clitoris, which frequently result in frigidity. Therefore, episiotomy as a routine procedure is the rule rather than the exception in the practice of modern obstetrics. The gratifying results to both patient and physician have firmly established it in its proper place.

With the increase of surgery in the perineal region, a clear understanding of the anatomy involved is of vital importance. Because of the many structures involved, their intricate relationships, and the confusing terminology, the average physician does not possess the same knowledge of the anatomy of this region that he does of other regions of the body.

* In private practice.

If the perineum is considered as the "inferior abdominal wall" with layers as definite and as important as the layers of the "superior (or anterior) abdominal wall," greatly improved results from surgery in this region are inevitable. A general surgeon would not close the "superior abdominal wall" without first identifying any approximately like structures, and yet, too frequently, a repair of the perineum is done by those who do not possess knowledge of even the essential anatomy of the region.

That faulty closure of the "superior abdominal wall" often results in incisional herniations is generally recognized; but obstetricians frequently fail to realize that faulty closure of the "inferior abdominal wall" almost invariably results in pelvic herniations such as rectoceles, cystoceles, urethroceles, and varying degrees of prolapse.

The layers that must be approximated may be summarized briefly as:

(1) Vaginal mucosa; (2) pelvic diaphragm; (3) urogenital diaphragm; and (4) skin.

When the bulbocavernosus muscles, which lie in the anterior compartment of the urogenital diaphragm, are approximated by the well-known "crown stitch," the result is a vaginal tone similar to that in a nulliparous woman.

The pudendal nerves are the chief source of muscular and cutaneous innervation in the perineum. These nerves readily lend themselves to local block due to their accessibility as they course through Alcock's Canal, which is on a level above the lower margin of the ischial tuberosities. The blocking of these nerves relaxes and anesthetizes the perineum, and is often used in conjunction with the infiltration method as described by Doctor Huff.

❦

Hall G. Holder, M. D. (1107 Medico-Dental Building, San Diego).—Modern obstetrics emphasizes episiotomy after elective low-forceps as proper procedure in primipara, in the best interests of mother and new-born. So widely has this teaching been accepted that it has become the rule rather than the exception. I will not labor this point, as I wish to indicate the value of this paper from a purely gynecological standpoint. The gynecologist sees all too many poorly done episiotomy repairs with associated perineal relaxation and subsequent gynecological sequalae. The statement has been made by older gynecologists that 60 per cent of gynecological surgery was incident to poor obstetrics and birth trauma. Episiotomy and elective low-forceps deliveries in particular were designed to avoid much of the sequelae of former years. Under proper management this is undoubtedly true; so we are indebted to Doctor Huff for his emphasis on episiotomy repair, the weak link in obtaining optimum results.

Episiotomy has been too lightly regarded as a most important operation, in fact, the most important in the conduct of the delivery, considering the future comfort and health of the mother. We, therefore, see many poorly executed and poorly repaired episiotomy incisions resulting in perineal relaxation comparable, or worse, than the results formerly obtained without its use and followed by the usual complications.

From a gynecological standpoint Doctor Huff's paper is timely in pointing very clearly to those employing episiotomy the necessity for accurate technique, if the best results are to be obtained and much subsequent morbidity avoided.

❦

Donald G. Tollefson, M. D. (511 South Bonnie Brae Street, Los Angeles).—Doctor Huff's presentation of the technique of mediolateral episiotomy calls our attention to a procedure which has been greatly neglected. It is an operation and should be performed as one.

The use of a scalpel has the advantage of a clean, sharp incision over the jagged irregular separation of tissue produced by a scissors. It allows better delineation of the various layers which permits a more accurate anatomical approximation. The elimination of external, nonabsorbable sutures might be criticized by those who feel that skin separation would be too apt to occur. This will seldom happen if asepsis is maintained and hemostasis is assured. The advantages as enumerated warrant the trial of this very complete, yet practical technique.

REGIONAL ANESTHESIA FOR ORTHOPEDIC OPERATIONS*

By Charles F. McCuskey, M.D.
Glendale

Discussion *by Alfred Edward Gallant, M. D., Los Angeles; Hugh Jones, M. D., Los Angeles.*

THE routine use of general anesthesia by orthopedic surgeons has been quite universal. This has been due in great part to lack of familiarity with regional technique and failure thereby to obtain complete anesthesia when operations have been attempted with regional block. We have no anesthetic agent or method that assures perfect results in every instance. In many orthopedic procedures regional anesthesia offers the patient greater safety and comfort during and after the operative procedure than can be obtained with any form of general anesthesia.

Three primary factors enter into the successful use of regional anesthesia:

1. Preliminary medication selected to meet the requirements of each case.
2. Potent, freshly made solutions of the anesthetic agent, of proper concentration.
3. Skillful blocking of the operative area.

PRELIMINARY MEDICATION

Preliminary medication plays an important part in the success or failure of any type of anesthesia. In regional anesthesia we try to give sufficient medication to allay nervousness and fear, but not enough to make the patient irresponsible and uncoöperative. To accomplish this the dosage must be selected for each patient. A combination of one of the barbituric acid derivatives and a narcotic will usually prove adequate. In some instances it has seemed advisable to give a hypodermic of morphin about one and a quarter hours prior to the injection, followed in about thirty minutes with a barbiturate. This gives us the advantage of the narcotic effect for the painful injection and allows the full effect of the hypnotic during the operation, when the patient is free from painful stimuli.

SOLUTIONS

Procain is our safest and best regional anesthetic agent. To avoid error and failure to obtain anesthesia due to injection of improper solution, it is advisable to prepare fresh solutions for each case. This is much more satisfactory than depending on novocain solutions prepared by some member of the surgical nursing staff, or by local pharmacists. By using 5 cubic centimeter sterile ampoules of 20 per cent novocain as put out by the larger pharmaceutical houses, this is a simple procedure. One of these ampoules diluted to 50 cubic centimeters with normal saline gives a 2 per cent solution, 100 cubic centimeters, 1 per cent, and 200 cubic centimeters, 0.5 per cent. Approximately

* Read before the Anesthesiology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

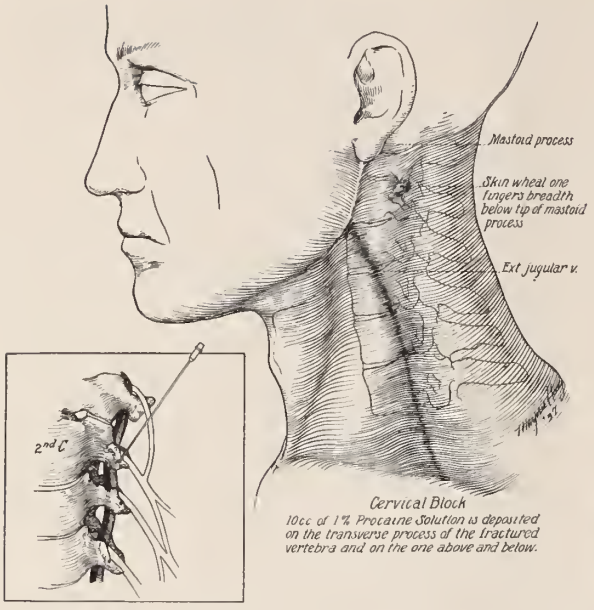


Fig. 1.—Deep and superficial landmarks for cervical block.

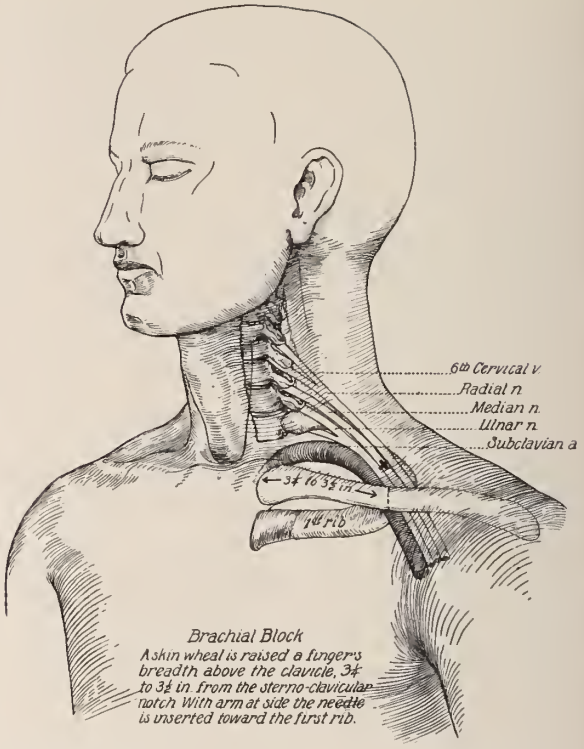


Fig. 2.—Position of clavicle and first rib in relation to brachial plexus.

6 minims of adrenalin is added to each ampoule for its local vasoconstrictor action, except when the patient is suffering from a toxic thyroid condition, or severe myocardial damage. The solutions should be at about body temperature when injected. Warmer solutions produce anesthesia more rapidly than cold, due to a more rapid absorption; but the duration of the anesthesia will be reduced proportionately.

SKILLFUL BLOCKING

Patients are not capable of judging whether they have had a good or bad general anesthetic. When they remain conscious throughout the entire operative procedure, as they do with regional anesthesia, they are the best judges of the success or failure of the method. Most patients are willing to stand some discomfort during the injection. If the operative procedure following this is also painful, we cannot expect them to be enthusiastic boosters for the method.

The novocain solution should be deposited in close proximity to the nerves with as few needle punctures as possible. The anesthetist making the injection should be sufficiently familiar with the operative procedure to assure anesthesia of the entire operative field. Failure to have anesthesia of a very small area may result in the total failure of an otherwise satisfactory block.

CERVICAL PLEXUS BLOCK

The use of block anesthesia of the cervical plexus is limited in orthopedic surgery to laminectomy and the reduction of fractures or dislocations of the cervical vertebrae. It offers a greater margin of safety for the reduction of cervical fractures than any other type of anesthesia. With the patient conscious and able to coöperate, it is possible for the surgeon to tell immediately if he should overcorrect the deformity and cause compression of the cord where none existed previously. For this procedure 10 cubic centimeters of 1 per cent novocain is deposited on the transverse processes of the fractured vertebrae and of the one above and below. The method of approach to the processes is determined by the location of the fracture and the patient's condition. Whenever possible the lateral approach as described by Labat is the one of choice. (Fig. 1.) If the sixth or seventh cervical vertebrae are involved, they may be approached from either the lateral or posterior position. In the posterior position a technique similar to paravertebral block in the upper thoracic region is used.

OPERATIVE PROCEDURES ON THE ARM

Regional anesthesia is the method of choice for long operative procedures on the arm. Anesthetic shock for long operations is reduced to a minimum, and when the injection is made correctly, the operative procedure is painless. It is particularly indicated for emergency traumatic surgery, as there is always an increased risk in administering an inhalation anesthetic to a patient that has not been properly prepared and premedicated.

Of the regional procedures that may be used on the arm, this discussion will be limited to brachial plexus block; although, for some cases, blocking of the nerves at the elbow or wrist may be sufficient. Brachial plexus block gives complete anesthesia of the entire forearm; if anesthesia of the shoulder, or upper arm, is desired, it can be obtained by placing a superficial injection around the shoulder, or upper arm, as indicated. The anesthesia obtained will ordinarily last for one and one-half hours from the completion of the injection. If the need for a longer period of an-

esthesia is anticipated, the needles may be left in place and additional novocain added as necessary. By this means anesthesia has been maintained for tendon repair for over four hours.

The technique for brachial plexus block is one of the easiest of our regional procedures, if one will keep in mind the important anatomical structures. The chief difficulty is encountered in accurately locating the mid-point of the clavicle, and in depositing the solution at the proper depth. If it is possible to palpate the subclavian artery, this difficulty is immediately overcome, as the injection can be made just lateral to it. The sternoclavicular junction can always be palpated easily; and if a wheal is raised a finger's breadth above the clavicle, three and a quarter to three and a half inches from the sternoclavicular articulation, this will practically always be over the plexus. The patient's arm should be at the side, and not extended on an arm board. (Fig. 2.) The needle is then inserted toward the first rib. If paresthesia is obtained to the hand, the injection is made immediately. By keeping in mind the relationship of the nerve trunks, it is easy to decide whether to move the needle inward or outward from the midline, as the ulnar trunk lies closest to the artery. Thus, if paresthesia is obtained to the thumb and forefinger, the next needle is inserted slightly closer the midline for the ulnar branch. If no paresthesia is obtained, the needle is withdrawn about one centimeter from the rib and the 2 per cent procain solution is deposited at that level. From 20 to 30 cubic centimeters of solution placed at the proper depth will spread over quite an area, so that paresthesias are not essential for obtaining complete anesthesia.

In a series of forty brachial blocks during the past three years, one was for open reduction of the clavicle, one for shoulder operation, one for Dupuytren's contracture, and the rest were for open or closed reductions of fractures of the upper or forearm and tendon sutures. In one instance where an open reduction at the elbow was done, a second operation became necessary and the patient requested this type of anesthesia. Satisfactory anesthesia was obtained in all of these patients for one and one-half hours, except in the case of one closed reduction, and that patient's fracture was reduced without the use of general anesthesia.

PARAVERTEBRAL BLOCK

Paravertebral block is a method to be considered for laminectomys for any purpose, and for Hibbs and Albee operations in particular. When used for the Albee operation, it is also necessary to block an area over the tibia for removal of the bone graft. Due to the restriction of breathing when it is necessary to operate upon patients lying on their face, our choice really lies between general anesthesia, using the intratrachial technique, and regional anesthesia. Considering the safety of the patient during the operative procedure, regional anesthesia is the method of choice. The dangers of postoperative anesthesia complications are also greatly reduced.

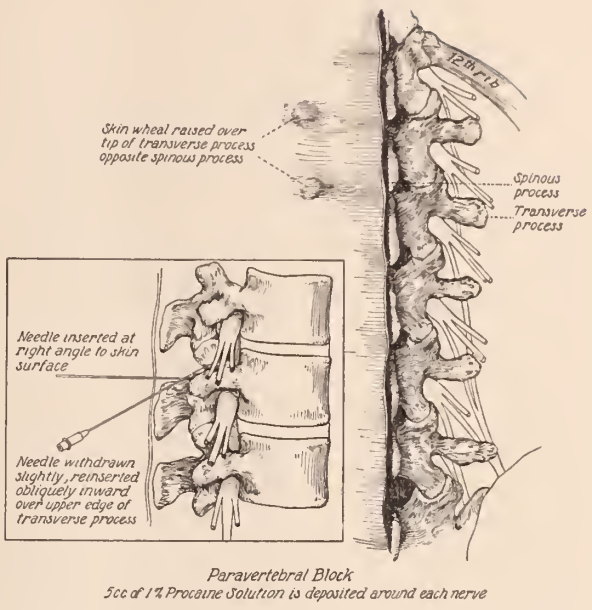


Fig. 3.—Superficial and deep landmarks for paravertebral block in the lumbar region.

The technique of paravertebral block varies slightly, according to the area involved. In the lumbar region the transverse processes lie directly opposite the intraspinous notch, and the skin wheal is raised at this point about an inch from the midline. (Fig. 3.) As we ascend the vertebral column, the wheals are raised about an inch from the midline, but higher in relation to the notch until, in the upper thoracic, they are raised opposite the spinous process itself.

The needle is first inserted at right angles to the skin until it makes contact with the transverse process. It is then withdrawn and reinserted, inward and upward over the edge of the transverse process. Approximately 5 cubic centimeters of 1 per cent novocain is injected around each nerve. The line of incision may then be infiltrated with .5 per cent procain as an adjunct to the anesthetic, and to promote hemostasis. This procedure is not essential, and if there is any contraindication it may well be omitted.

Paravertebral block is also of value in the reduction of vertebral fractures, and has the same advantages as cervical block for this purpose.

CONCLUSIONS

Regional anesthesia offers the patient greater safety for the orthopedic procedures enumerated than general anesthesia.

The dangers of postoperative pulmonary complications are eliminated, except those that are embolic in origin.

When the novocain solution is placed properly, operative procedures may be performed without pain.

Anesthetic and operative shock are reduced to a minimum.

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DISCUSSION

Alfred Edward Gallant, M.D. (727 West Seventh Street, Los Angeles).—Doctor McCuskey's paper offers a very interesting phase of anesthesia for orthopedic operations, and a practical application of what he has stated and outlined is of much value because it allows the surgeon a better facility for performing his work. It has been found that regional anesthesia minimizes the possibility of shock, especially in those cases which are bad risks. In the past four years we have employed this method in about thirty cases in which Doctor McCuskey provided the anesthesia technique. To cite a few of these cases, a woman who had both bones of the left forearm fractured and a fracture of the left patella, regional anesthesia was given, under brachial block for the correction of the forearm fractures, and a femoral block for the patella fracture. There had been a head injury in this case, and I am of the opinion that an ether anesthesia would not have been a satisfactory method. The use of the regional blocks proved to be of much advantage. A second instance, a man with a spiral fracture of the humerus, brachial block was employed. This man had been a heavy drinker, and it was certain that recumbency, if the Bardenhauer method had been employed, would not have been satisfactory. The regional block allowed us to apply a shoulder spica and the patient became ambulatory. Another instance of a comminuted spiral fracture of the right humerus in a young woman where a head injury had also existed, made a satisfactory handling of the case a relatively simple procedure. A spiral fracture of the shaft of the humerus in a woman over eighty years of age was satisfactorily reduced. Patient was allowed to become ambulatory, and much more comfortable than in cases where there were recumbency and extension. Another instance, a man of eighty-four years of age with fractures of both tibiae, and right humerus, involving the elbow joint, a very bad risk and treated with regional anesthesia, resulted in satisfactory reduction and outcome. Therefore, I am of the opinion that regional anesthesia will gradually become more universally used because of its possibilities in orthopedic problems.

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Hugh Jones, M.D. (201 Medical Office Building, Los Angeles).—More extensive use of regional anesthesia in orthopedic operations will probably come about as anesthetists perfect the technique to the point where the surgeon and patient can confidently expect a painless operative procedure. The surgeon himself may be able to acquire this skill; but in general it is better to trust this work to an anesthetist whose experience is such that satisfactory anesthesia can be counted upon regularly.

The cervical plexus block for manipulating fractures of the cervical spine has been very comforting to me, because I have felt very uneasy about assuming the responsibility in such a case, with the weight of the head and relaxed neck as it hangs with the helpless patient under general anesthesia.

The brachial plexus block has been very helpful, indeed, for time-consuming tendon and nerve repair. A particular advantage is usually found in the ability of the patient to contract the various muscles, and this helps in the identification of the different tendons. This voluntary control is also appreciated when it is possible to try out the return of function before closing the wound. Leaving the needle in place to reinforce waning anesthesia, is an advantage easily appreciated.

More frequent use of paravertebral anesthesia should be made in the Hibbs and Albee operations, as well as for laminectomy. For the Albee operation, the leg can well be anesthetized by surrounding the operative site for the removal of the graft from the shin.

In emergency work one feels much safer about a patient with a full stomach, if the dangers incident to vomiting while under the anesthetic can be avoided. Local anesthesia provides this factor of safety.

COMPENSATORY PRESSURE IN ANESTHESIA FOR THORACIC SURGERY*

By W. Lawrence, M.D.
San Francisco

Discussion *by William Neff, M.D., San Francisco; G. D. Delprat, M.D., San Francisco.*

OCCASIONALLY, during the task of administering an anesthetic one is confronted by a sudden crisis which threatens the safety of the patient, disturbs the surgeon, and chills the spine of the anesthetist. At a time such as this it is essential to analyze the situation promptly and to institute the proper corrective measures. This is especially true when seemingly indicated readjustments in the anesthetic fail to produce the desired result.

Such a sudden crisis may occur during operations upon the thorax which necessitate the opening of a hole of any considerable size in the chest wall. The following is somewhat the order of the train of events as they take place:

A patient under nitrous oxid anesthesia, reinforced by local infiltration, chloroform, cyclopropane or intravenous barbiturates, may be breathing quite evenly and showing no signs of either anoxemia or overdosage of anesthesia. When the thorax is opened, however, the respiratory rate increases, the depth of breathing increases, the pulse rate and pulse volume increase and cyanosis appears. An increase of the oxygen flow to the patient is the first consideration, and is promptly provided. The desired evidence of oxygenation does not result. Cyanosis becomes deeper and asphyxial spasm begins to manifest itself. The pulse becomes more rapid and more feeble. The pupils dilate and the skin becomes mottled. Suddenly, just at the moment when oxygen in the lungs is of the utmost importance, the anesthetist is confronted with the most distressing of all conditions in inhalation anesthesia, *i. e.,* spasm of the glottis and of the respiratory muscles. That death does not more often supervene is undoubtedly due to the fact that, after the fatigue of the prolonged asphyxial spasm, a sufficient relaxation of the glottis occurs to permit the anesthetist to force a small amount of oxygen into the lungs under pressure, and the patient revives with evidence of considerable shock. The abruptness with which the foregoing disturbance breaks into the course of the anesthesia is probably the reason why deaths at this point have been variously ascribed to embolism, acute dilatation of the heart, shock, collapse of the trachea, or status lymphaticus.

Convinced that the foregoing syndrome was, in most cases, due entirely to oxygen-want carried to the stage of asphyxia, I began to use increased pressure in the breathing bag promptly at the time the chest wall was opened, or when its rigid structure was disturbed by a resection of the ribs. The result of maintaining pressure during this period of the operation is so gratifying that I feel the subject is worthy of emphasis before this group.

* Read before the Anesthesiology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

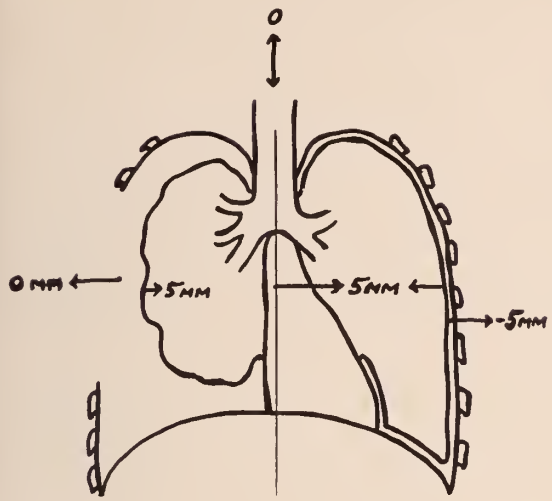


Fig. 1

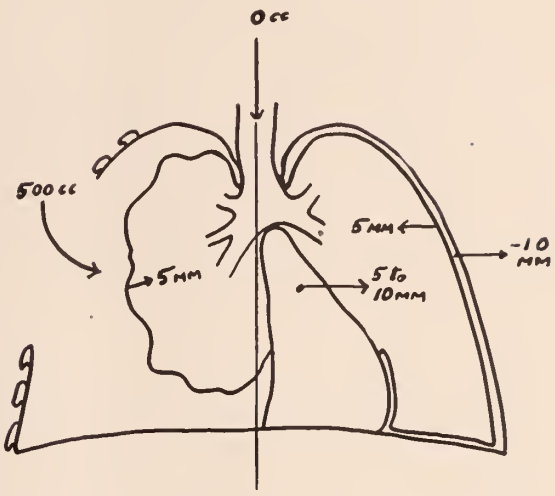


Fig. 2

Fig. 1.—Illustrating status of intrathoracic pressures during rest—right thoracic wall open. Intrapulmonary pressure 0.

Fig. 2.—Illustrating ineffectiveness of inspiratory effort when thorax is open. Intrapulmonary pressure 0. Note mediastinal displacement.

NORMAL ANATOMY AND PHYSICS OF INTRATHORACIC PRESSURE

When the thorax is at rest there exists in the potential pleural space a vacuum of 5 millimeters of mercury. This 5 millimeters vacuum is produced by the centripetal pull of the lungs, due to their own elasticity opposed by the semirigid structure of the rib-cage and diaphragm at the limit of relaxation. The mediastinum remains in the midline because the pull upon it is equal in both lateral directions.

Upon inspiration the intrapleural vacuum is increased to 10 millimeters of mercury, due to the enlargement of the chest cavity by the raising and expansion of the rib-cage and the downward movement of the diaphragm. The 5 millimeters centripetal contraction tendency of the lung is overcome by the 10 millimeters vacuum, and the lungs fill. The mediastinum remains balanced in the midline position.

It is pertinent to observe here that the flaccid contents of the mediastinum, and its somewhat narrow anterior and posterior attachments, make it a quite movable structure.[1] In the cadaver with normal lungs it has been observed that the mediastinum will move some three inches to the left and some two inches to the right from the normal midline position.

Another anatomical consideration to be borne in mind is that the area of the normal glottis is about 2.5 to 3.0 square centimeters.

DISTURBED INTRATHORACIC PRESSURES

Assuming that an opening of considerable size is made in the right thoracic wall, and the left remains intact, it becomes evident that the intrathoracic pressure relationships are promptly disturbed. At rest the negative pressure in the right pleural cavity is now zero and the 5-millimeter pull of the left lung displaces the mediastinum somewhat to the left. (Diagram 1.)

The physics of the failure of the respiratory system becomes evident upon consideration of a diagram of the open thorax during inspiration. (Diagram 2.) The inspiratory effort results in an ingress of air into the right pleural cavity as the thorax expands, the air taking the course of least resistance. The mediastinum is displaced further to the left by the 10 millimeters vacuum of the left pleural cavity which is now added to the 5-millimeter contracting pull of the left lung. Against these forces there is now no balancing pull in the right thorax. The mediastinal displacement thus makes the inspiratory expansion of the left thorax almost entirely ineffective, in so far as aeration of the left lung via the trachea is concerned.

Thus the quantity of air or gas entering the unoperated lung under the foregoing conditions will be in inverse ratio to the disproportion between the opening in the chest wall and the opening of the glottis, *i. e.*, if the disproportion is great the amount of air or gas entering the left lung will be small. It has been estimated that the limit of disproportion between the size of the opening in the glottis and the opening in the chest wall, which is compatible with life, is as one to twenty. In other words, if an opening is made in the chest wall having an area of more than 50 square centimeters, the patient will die within a short time of asphyxia in an ordinary atmosphere.[2]

During the expiratory phase of the respiratory cycle the mediastinal structures move to the right, and the air is emptied from the right thoracic space through the thoracotomy opening, and the status is again as described during rest.

The side-to-side movement of the mediastinum with respiration has been referred to as "mediastinal flapping," and is comparable to the vigorous movement of the slack sails of a yacht as the air pressure shifts alternately from side to side.

It becomes evident that, with an insufficient exchange of anesthetic gases having a lowered oxygen

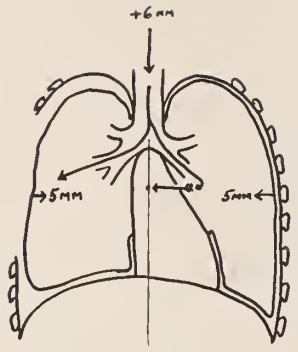


Fig. 3

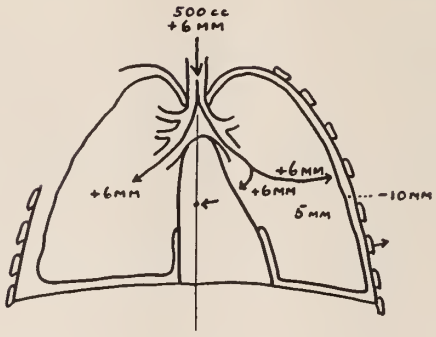


Fig. 4

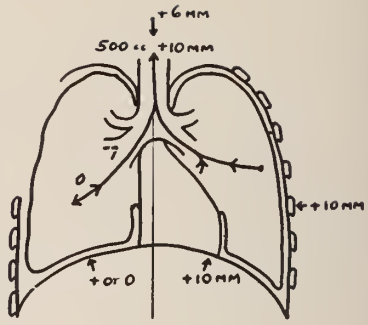


Fig. 5

Fig. 3.—Illustrating effect of increased intrapulmonary pressure during rest when thorax is open. Note indicated mediastinal stabilization.

Fig. 4.—Illustrating effect of increased intrapulmonary pressure during inspiration when thorax is open. Note indicated mediastinal stabilization.

Fig. 5.—Illustrating expiration against increased intrapulmonary pressure. Right lung remains inflated, mediastinum stabilized and the left lung emptying.

percentage, between alveoli and breathing bag the patient must of necessity very soon progress into a state of anoxemia, if a correction is not made to offset the disturbed intrathoracic pressure relations. The overactivity of the respiratory muscles, and the generalized muscle spasm which follow, cause an increased metabolic rate which still further increases the deficit between oxygen requirement and oxygen supply. Furthermore, the spasm of the glottis, which almost invariably accompanies anoxemia, also impedes the exchange of gases between lungs and breathing bag.

It is quite the natural thing for the anesthetist, having increased the oxygen flow to the patient, to be lulled into a false sense of security. This will of necessity be of brief duration because, in a matter of seconds, the patient passes through a convulsion and into a state of complete asphyxia. The pupils dilate, the skin becomes mottled, respiratory efforts cease, and the pulse becomes imperceptible. The fact will bear repeating that the unbelievably sudden climax of the syndrome makes one feel, erroneously, that the disturbance must be circulatory in nature and the etiology something akin to embolism.

The so-called "paradoxical breathing," manifested after closure of the wound, undoubtedly belongs in this classification of disturbed intrathoracic pressures. The flaccid operated side falls inward with inspiration and moves outward with expiration. The mediastinum probably exhibits the same undesirable lateral movement seen when the chest is open. I have observed rather severe anoxemia resulting from this condition at the close of thoracic operations.

FACTORS INFLUENCING DISTURBED PRESSURES

Fixation of the mediastinum by disease, thickened pleura, accommodation resulting from long-standing treatments, such as pneumothorax, pleural adhesions, and probably other more obscure factors, serve to neutralize to some extent the disturbance of intrathoracic pressures by operations.

COMPENSATORY PRESSURE

The Sauerbruch chamber was designed to create the vacuum necessary to offset the disturbance of intrathoracic pressures resulting from opening the chest wall.[3] It consists of an air-tight, steel chamber from which sufficient air may be pumped to create the desired vacuum on the inside of the chamber. The patient's body and the entire operating team are inside the chamber, and the patient's head and the anesthetist are outside. As may be readily imagined, the apparatus is cumbersome and expensive.

Since it makes no practical difference, so far as end-results are concerned, whether the difference in pressure is obtained by lowering the extrapulmonary pressure or by increasing the intrapulmonary pressure, it is certainly more feasible to employ the latter means of making the readjustment. For this purpose the Brauer high-pressure apparatus[3] was devised. It is also unnecessarily complicated.

We have been able to obtain a satisfactory stabilizing effect upon the mediastinum and aeration of the nonoperated side by maintaining a pressure just sufficient to overcome the 5 millimeters centripetal contraction tendency of the lungs. A pressure of about 6 millimeters of mercury has been quite sufficient in most cases.

The essential features of a satisfactory set-up for the successful maintenance of compensatory pressure are as follows:

1. A clear airway.
2. Air-tight connections in apparatus and between face and mask.
3. Pressure gauge in the circuit.
4. Absorber to dispose of expired carbon dioxid.
5. Accurate oxygen flow gauge.

An increased flow of oxygen and anesthetic gases may be maintained to offset small leaks in the apparatus and about the face.

With this arrangement the pressure throughout the entire system and into the patient's lungs is built up until the desired level is reached and maintained so until the thorax is closed.

During rest the pressure serves merely to hold the mediastinum in the normal midline position. (Diagram 3.) The lung on the open side, having partially collapsed, appears to withstand more pressure than we would suppose, for we have not

observed dangerous overdistention at even a pressure of 7 millimeters.

The effectiveness of sustained pressure becomes most evident during inspiration. (Diagram 4.) It now serves to hold the mediastinum steady in the midline position, while it also inflates the left lung to the limits of the expanded thoracic cavity. Gases bearing fresh oxygen thus enter the left lung. The right lung remains inflated and immobile. Whatever undesirable effect there may be upon the right lung from distention must be tolerated for the time being.

During the expiratory phase of the cycle the resilience of the left thoracic wall and diaphragm, plus the 5 millimeters contracting tendency of the left lung, are sufficient to overcome the 6 millimeters positive pressure of the breathing bag, and the atmosphere of gas in the left lung is propelled back into the breathing bag through the carbon dioxid absorber. The right lung and the mediastinum are held stable in their previous positions. (Diagram 5.)

A prompt improvement in an anoxemic patient's condition will be noted immediately upon the institution of sustained compensatory pressure sufficient to overcome the centripetal contraction tendency of the lungs, and sufficient to immobilize the mediastinum.

Pressures beyond 10 to 12 millimeters of mercury will result in rupture of the alveoli, and should be avoided.

Asphyxial symptoms may also appear during local or intravenous anesthesia, although not so rapidly as when the atmosphere has been reduced to a ten per cent oxygen content, as in nitrous oxid anesthesia. I have observed the onset of asphyxia while administering continuous intravenous anesthesia for thoracoplasty, and have corrected the condition by strapping on a mask and supplying the needed compensatory pressure while continuing the injection.

There is no doubt but that the involuntary effort of breathing against pressure must of necessity exhaust the patient after a short time, and certainly the operation should be terminated with the greatest possible speed.

Although I have been using the ordinary rubber-cushioned face mask strapped to the head, occasionally intubating the trachea transnasally with McGill tubes, with much success, I feel that the method can stand considerable improvement. The following is a technique which appears to have many good features, and which I hope to give a trial in the future:

A SUGGESTED TECHNIQUE FOR COMPENSATORY PRESSURE

1. Premedication with a large, but safe, dose of some barbituric acid derivative one and one-half hours preoperatively.
2. Morphin and hyoscin forty-five minutes preoperatively.
3. Anesthetization of the pharynx and larynx with a spray.
4. Intravenous barbituric acid derivative sufficient to give good relaxation of the jaw.
5. Intubation of the trachea, with a semi-rigid tube with an inflatable cuff to seal the space between the tube and the wall of the trachea (as described by Waters).[4] Intubation of the bronchus to the good lung would probably be an advantage in cases of bronchial fistula or bronchiectasis.
6. Inhalation anesthesia with nitrous oxid reinforced by chloroform, cyclopropane, or ether.
7. Suction to evacuate pus, blood, or mucus from the accessible branches of the bronchial tree beyond the end of the endotracheal tube.
8. Compensatory pressure during the periods of disturbed intrathoracic pressure.

SUMMARY

1. Normal thoracic pressures and anatomy relating to anesthesia have been reviewed.
2. The physics and anatomy of disturbed intrathoracic pressures and the ill effects thereof have been discussed.
3. The effects and method of instituting compensatory pressure have been described.
4. A technique is suggested for handling cases for thoracic surgery.

54 Brentwood Avenue.

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2. Wright: Applied Physiology, p. 382.
3. Oxford Surgery, Vol. 4, Part 1, p. 130, Fig. 35, and p. 131, Fig. 36.
4. Gale and Waters: Closed Endobronchial Anesthesia in Thoracic Surgery, Current Researches in Anesthesia and Analgesia (Nov. and Dec.), 1932.

DISCUSSION

William Neff, M.D. (Stanford University Hospital, San Francisco).—Doctor Lawrence has given us a most interesting paper on a subject which should be the concern of every anesthesiologist. When so many drugs, both volatile and nonvolatile, and techniques, ranging from intravenous barbiturates and endobronchial or endotracheal gases to subarachnoid block, are recommended for anesthesia in intrapleural surgery, it is apparent that all have their shortcomings. Regardless, however, of the agent or the technique, there is general agreement that compensatory pressure should be used. Dr. Harry Shields, senior anesthetist to the Toronto General Hospital, and Dr. I. Magill of London are two of the outstanding anesthesiologists who advocate the use of spinal anesthesia for intrapleural surgery. They have observed that if anesthesia to the third thoracic segment is produced, circulatory shock is far greater when the abdomen is opened for gall-bladder surgery than when the pleura is opened for intrapleural surgery. These observations, emanating from such keen minds, are worthy of further study. Endobronchial anesthesia is still in the experimental stage. One must seriously consider the partially collapsed lung which is blocked, but in which the blood supply still remains. It is clinically most difficult, if not impossible, even when agents are used which permit double the atmospheric concentrations of oxygen, or increased pressure is also maintained, to prevent the symptoms of oxygen lack. Dr. E. Rovenstine of the Department of Anesthesia at Bellevue Hospital, recommends total blocking of a bronchus, not to exceed eight minutes, until the ligature has been applied. It should be remembered, also, that intubation of the left bronchus, with a thin-walled, large lumen tube is not easy.

Direct vision endotracheal intubation with a large lumen, thin-walled tube surrounded by a Waters-Guedel inflatable cushion, under inhalation anesthesia, is the method which, because of its controllability, appeals to me most. To produce adequate pressure to approach a more rigid mediastinum, the application of hand pressure to an already moderately distended breathing bag attached to a Waters (to and

fro) soda-lime canister which, in turn, is connected to the endotracheal tube, is simple, safe, and efficient.

In so far as agents are concerned, one must keep in mind that, where mixtures of agents are used, the metabolic disturbances are always particular to the most toxic; so that when chloroform or ether has been used to fortify nitrous oxid, ethylene, or cyclopropane, one must think of toxicity in terms of the former group rather than the latter.

❊

G. D. Delprat, M.D. (384 Post Street, San Francisco). Doctor Lawrence has presented very clearly the technical considerations of anesthesia on the open thorax. As is evident in his paper a clear conception of the underlying physiology on the part of the anesthetist is an absolutely necessary and fundamental prerequisite. Then follows the need of his ability to recognize the symptoms of disturbed physiology, and his prompt correction of gas concentrations and pressures. No anesthetist without this fundamental background should permit himself to undertake any chest operation anesthesia; for even should an operation be planned that does not contemplate opening the pleura, yet this possibility is ever present. Under certain circumstances, for instance, a simple rib resection for empyema in a sick individual may be very shocking if the thoracic pressure relationships are abruptly disturbed. The technical points of this subject are ably presented. No discussion of the paper, however, would be complete without reference to the art of anesthesia which all surgeons will admit is nowhere so well demonstrated as by the competent "chest anesthetist."

There is unquestionably no comfort so great to the surgeon as the knowledge that the man behind the anesthetist's screen is alert, competent and reliable. The feeling that it is not necessary to glance over the drapes at that visible portion of the patient's face, and that it is not necessary to give directions to an already harassed anesthetist, is worth untold riches. To be able to ask, "How is the patient?" and to know that the reply, "He is all right," or "He will be all right in a minute," means what it says, is as great a comfort as the reverse is a torment. While Doctor Lawrence would be the last person to admit it, I will say that he gives just such an anesthetic!

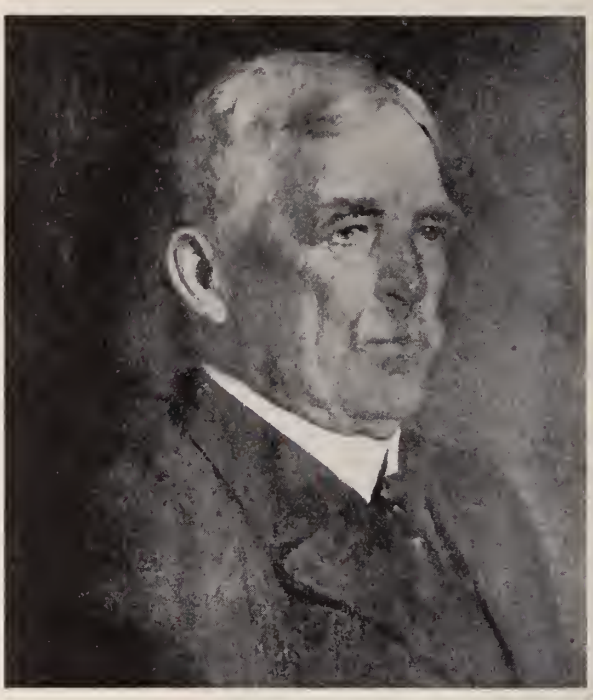
THE LURE OF MEDICAL HISTORY†

THOMAS WATERMAN HUNTINGTON
A. B., M. D., LL. D.
V*

By Wallace I. Terry, M.D.
San Francisco

Doctor Huntington was born on January 16, 1849, at Rockford, Illinois, but sprang from New England stock. He was a descendant of Samuel Huntington, a prominent clergyman of Massachusetts and a signer of the Declaration of Independence. His father, Charles, was also a clergyman and an educator, and it was at his hands that the subject of our sketch received his early education. Doctor Huntington was graduated in 1871 from the University of Vermont, which institution, in 1913, also conferred on him the degree of LL.D.

As his finances were low after leaving college, he taught school and later entered Harvard Medical School, where he received his M.D. degree in 1876. At Harvard and at the Massachusetts General Hospital, where he interned, he came under the influence of such teachers as Oliver Wendell Holmes in anatomy, Porter, Warren, Homans, Bigelow, and Cheever in surgery, Fitz in pathology, and others prominent in the profession.



THOMAS W. HUNTINGTON
1849–1929

He began to practice in Nevada while it was still a frontier region, and there became a surgeon for the Central Pacific Railroad. His work in the latter capacity led to his appointment, in 1882, as assistant chief surgeon of the company hospital in Sacramento, the first hospital in the world devoted exclusively to railway employees. In 1885, he was made chief surgeon, and held that post for thirteen years, when he came to San Francisco and succeeded Robert A. MacLean as professor of clinical surgery in the University of California Medical School.

From 1882 to 1919, Doctor Huntington was quite a steady contributor to surgical literature. His papers dealt with a wide variety of topics, such as antisepsis and asepsis, surgery of the extremities, intestinal obstruction, gunshot and stab wounds of the abdomen, and pyloric stricture, for which he did Loreta's operation in 1889. He also wrote about aneurysm, appendicitis, hernia, nephrolithotomy, amputations, fractures, splenic cysts, stomach and gall-bladder surgery, and x-ray burns.

Some of his papers are important from a historical, as well as factual standpoint. As early as 1882, for example, he read a paper on "Antiseptics, as Applied to Surgical Art," from which I quote: "Without personal experience or experiment, with no ocular proof or demonstration, I have become a convert to the theory which has lent inspiration to surgery, and has ushered in a brighter era for sufferer and attendant alike." Two years later he

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

This is Paper V of the series. For other articles in the symposium, see California and Western Medicine, November, 1937, page 321; December, page 405; January, page 27; February, page 114.

reported over one hundred cases treated antiseptically, and said: "Under the old régime, we dressed all wounds once and the more important ones twice or three times daily. The dressings were many times stiffened and glued firmly to the skin by inspissated pus; lint fiber became incorporated in granulating surfaces, and large poultices weighed heavily upon throbbing sensitive areas. Each and all were torn from their moorings with a refinement of torture that would have delighted the demons of an inquisition. How different now! Where once in a given case we witnessed from fifteen to thirty repetitions of the foregoing scenes in a fortnight, we now renew our dressings once or twice."

I am confident that in 1882 very few surgeons in the West made any serious efforts to acquire an antiseptic or aseptic technique—in fact, Listerism had few adherents, many opponents, and many who knew nothing of the matter or were supinely indifferent.

On August 20, 1891, Doctor Huntington did the first successful appendectomy in the Far West. He had carefully observed the man several times during attacks, which he diagnosed as acute appendicitis, and waited for an interval period before operating. This case did much to enhance his reputation as a surgeon of diagnostic and technical ability.

In operations for hernia he also showed his progressiveness; for in 1891 he reported five operations by the Macewen method for the radical cure of hernia. In 1895, he detailed four operations on the gall-bladder.

He kept constantly abreast of the newer advances in surgery through the literature, and by faithful attendance at and participation in medical meetings, and by frequent trips to the medical centers of this country. His association with James H. Parkinson, a former president of the California Medical Association, and others, on the editorial board of the Sacramento (later the Occidental) *Medical Times,* gave him the opportunity to abstract surgical literature. Most of his earlier original contributions are to be found in those journals.

He was president of the Sacramento Society for Medical Improvement in 1891. As chairman of the Section on Surgery of the American Medical Association in 1912, he devoted his address to "The Hospital Problem," and made a plea for the inauguration of a "system of organized inspection and classification of all American civil hospitals"—a suggestion, however, which was not acted upon for many years. Also, in 1912, he was president of the California Medical Association.

In 1917, at the age of sixty-eight, he was a member of the American Red Cross Commission to Italy, and spent some time near the battlefields of Europe to report on hospital and other conditions.

Another high honor accorded him was election, in 1918, to the presidency of the American Surgical Association, when he discussed industrial medicine and health insurance.

He regarded his civic duties seriously. He served on the Board of Education in Sacramento; on the San Francisco Board of Health, shortly after the big fire when there were many problems to be solved; and on the directors' board of the Veterans' Home at Yountville.

He came to the University of California Medical School well equippel to teach and with a wealth of experience. He was a fluent speaker, a graceful, clever and conscientious operator, and was recognized as a master surgeon. He did much toward the establishment of the University Hospital. He retired as professor emeritus in 1912, after fourteen years of active teaching, but his vigor and clear intellect were changed but little in the intervening years until his death on April 19, 1929, at the ripe age of eighty.

384 Post Street.

CLINICAL NOTES AND CASE REPORTS

THYROIDISM*

By JOHN W. SHUMAN, M.D.
Los Angeles

THYROIDISM is like a two-story house with a cellar and attic.

The first floor resembles the normal thyroid state—the average individual. This type receives little notice from a thyroid, or from any other standpoint. As long as one remains on this floor all is well.

HYPOTHYROIDISM

However, as we descend into the cellar of *hypothyroidism,* too little thyroid activity is expressed. Fatigability and slow metabolism are encountered, accompanied by slow thinking, slow ideas, slow, nervous impulses, and slow everything. This is carried even to the floor of the cellar where, with its thick mind, thick skin, and coarse, brittle hair, *myxedema* vegetates.

This state of marked thyroid inactivity is acquired as a result of disease, or often as a result of injudicious surgery.

They are baffling in that they present certain symptoms that are analogous to the neurasthenics' complaints, but there is this difference: that while the neurasthenic excuses himself for not doing things, because of the complaints, and more or less hides behind them, the hypothyroid individual is annoyed at the handicap that these things he speaks of impose upon him, and tries to get ahead, regardless, with the resultant unavoidable fatigue.

We must not expect mental lethargy and sluggishness in all hypothyroids. Much depends upon the age at which the thyroid state appears. If it occurs after the individual's characteristics and mental pattern are set, then mentality is not altered. If hypothyroidism occurs early in life, then mental development is retarded, as well as physical vigor.

A further note of warning: One cannot always rely on the first basal metabolic rate reading as truly indicative of the patient's metabolism. In many hypothyroids there is a general neuromuscu-

* Presented to the Los Angeles County Hospital postgraduate course, November 22, 1935.

lar tension, which causes the first determination to be higher than a true basal rate.

A recent experience with a patient who presented all symptoms of the hypothyroid state, but was exceedingly nervous over a family conflict, found the first basal metabolic rate plus five. However, after the administration of two grains of desiccated thyroid gland daily for a week, we found the second reading minus twenty! There is, too, this difference between the neuropath and hypothyroid: the neuropaths make excuses because of their inability; the hypothyroid man goes until he breaks.

The clear-cut picture of disturbed thyroid states are not so difficult. The borderliners and mixed types are difficult, and these latter far outnumber the former. They blend into each other and often overlap, with no clear line of demarcation. The cretes, the extreme myxedemas, and the strongly hyperthyroids are easily recognized. The others we must study very carefully.

HYPOTHYROIDISM

As one ascends the steps from the first to the second floor, we find action. Hyperthyroidism begins to show with restlessness, nervousness, fast metabolism, fast mind, and fast everything. Most of us would rather be the second-story type than "sub," or just normal all of the time. This mild or intermittent "hyper" is the type which drives the world—and wears out in so doing—believing, no doubt, that it is much better to wear out than to rust out! The hyper type of mankind has made history; for example: Moses, who, in impulsiveness, slew an Egyptian taskmaster; David, who in his warmth for a woman had a husband killed so that he could take her to wife and produce Solomon; Peter, who, on account of his rashness, repentiveness and faithfulness, became "The Rock upon whom Christ built His church." Constantine, Frederick, Caesar, and Kaiser Wilhelm were not hypos. Neither are Mussolini. Roosevelt, and our own Los Angeles Aimee.

SUPERHYPERTHYROIDISM

As we ascend higher up toward and into the attic of this house of thyroidism, dire trouble is met and real suffering is found because in this attic dwells a too fast metabolism, which beats the heart to death, and produces active psychoses with coma and collapse: it is up there that we recognize an aggravation of the same symptoms which made some men famous. The *three "t's"* of *toxic thyroidism* are *tumor, tremor,* and *tachycardia.* These asthenic psychoses are the diametrical opposite of the asthenic psychoses of myxedema.

Thyroid enlargement (goiter) has held the stage for years. Folks will still continue to think goiter whenever thyroid trouble is mentioned. There are two times in the human's life when the thyroid enlarges, namely, puberty, and the climacteric (stress periods for both sexes). The female experiences two other times—menstruation, and pregnancy.

Eighty per cent of parturients have physiologic enlargement of their thyroid glands. In these, complications of pregnancy are rare. They are not only good nursers, but they make excellent mothers.

Many surgeons point with undue pride to the neat little white line of their thyroidectomy scars.

BIMANUAL PALPATION OF THE THYROID

Feeling the thyroid gland by means of the old choking method, from in front, is not satisfactory. The method which employs both hands of the examiner is better. The choking method, that is, with one hand of the physician encircling a part of the patient's neck from in front, always produces a muscular defense.

With the bimanual method, the examiner stands behind the patient, the thumbs being placed on the back or sides of the slightly flexed neck, when, with the index and second fingers, the lobes of the thyroid can be located, and their anterior and lateral surfaces explored. The patient aids by swallowing, which causes the gland to slide up and down under the examiner's fingers. This simple procedure has found many a nodule which had escaped the other method.

INDIVIDUALITIES

When studying patients in regard to thyroidism, we must consider that triad which is always working and is never the same:

- THE TRIAD
 - 1. Patient
 - 2. Disease
 - 3. Doctor
- (1) Patient
 - Heredity — We are what our ancescestors and parents made us. Characteristics are born, not acquired.
 - Environment — Gives us our tastes and acquisitions.
 - Stimuli
 - Are intrinsic—chemical and infective, or
 - Extrinsic—fixed and adjustable.
- (2) Disease
 - Hyper
 - Latently toxic
 - Mildly toxic
 - Severely toxic
 - Hypo
 - Passively sub
 - Moderately sub
 - Severely sub

Take care of the simple goiter today, because it may become the toxic one of tomorrow.

- (3) Doctor
 - Surgeon—"Operate"
 - Internist—"Medicate"
 - General Practitioner—"Procrastinate"

Stimuli depends upon type, age, sex, and so forth. If they are "fixed," it is just too bad for all parties concerned. Nevertheless, we must consider them all adjustable, and try to adjust them.

We have failed frequently in securing a permanent arrest of toxic thyroidism or even in temporarily breaking the chain of events by removing five-eighths of the thyroid gland, the reason being that we did not remove the psychic stimulus at the same time, for example, a chronic worry. This

worriment excited the remaining thyroid tissue to hypertrophy and to yield sufficient thyroxin to produce a recurrent *thyrotoxicosis.*

Infections produce acute thyroiditis, which in convalescence produces hypothyroidism. Focal infections (sinus, tooth, and tonsil) are common causes for malthyroidism. Irritation from impacted teeth, especially third molars, is too frequently neglected.

Once malthyroidism, always malthyroidism, demanding the continued services of the clinician.

3780 Wilshire Boulevard.

LYCOPODIUM GRANULOMA, AN AVOIDABLE SURGICAL COMPLICATION*

By John W. Cline, M.D.
San Francisco

FOR many years, dusting powders containing lycopodium spores have been used for various medical and pharmaceutical purposes. They are still employed in many hospitals in the preparation of dry sterile gloves and the dusting of hands of the operating staff prior to drawing on the gloves. The physical properties of lycopodium spores make such powders superior to talcum for this purpose.

COMPOSITION OF DUSTING POWDERS

These powders consist largely, or entirely, of the spores of L. clavatum, a species of club moss belonging to the fern family. The spores are about 30 microns in diameter, are roughly spherical in shape, and are covered by spinous projections. The spines cause the spores to adhere to tissues and quickly embed themselves. They make a fine, smooth, light powder, which has been called vegetable sulphur because of its pale yellow color. Due to high oil content, the spores are not wet by water and float upon it. For the same reason they burn with a quick flash when ignited.

ACTION OF THE SPORES

The spores have the property of creating an intense foreign body reaction when embedded in tissues, and have been used for the production of granulomata in experimental animals.[1] Their capacity to produce similar lesions in humans seems to have been completely overlooked until mention was made of it by Roth[2] in 1921. More recently, excellent papers have been published by Antopol[3] and Erb.[4] The reader is referred to these publications for more detailed pathological descriptions, illustrated by excellent photomicrographs.

GROSS APPEARANCE OF "LYCOPODIUM GRANULOMA"

The term "lycopodium granuloma" was introduced by Antopol to indicate the lesion produced by lycopodium spores when present in human tissues.

The gross appearance of this condition varies according to the location of the lesion and the presence or absence of secondary infection. In the peritoneal cavity, there is marked resemblance to tuberculosis. Elsewhere there is a tendency to nodular form, but the chief characteristic is the laying down of dense fibrous tissue with the usual firmness of chronic granulomata. Discharging sinuses are frequent. On section, the pearly white fibrous tissue, with islands of cellular tissue and necrosis, is seen.

MICROSCOPIC APPEARANCE

Microscopically, the process is essentially granulomatous, consisting of granulation tissue with fibrosis and necrosis. There is a marked tendency to tubercle formation, with epithelioid cells and giant cells of both the foreign body and Langhans type. The lycopodium spores are seen in the granulation tissue or giant cells as yellowish, refractile bodies staining poorly with ordinary tissue stains. In cross section, they show a membrane, surmounted by spines, surrounding a granular center. Frequently the collapsed membrane without a center is all that remains. When the tissue is stained by the Ziehl-Neelsen method, the spores stand out as acid-fast bodies.

Macroscopically and microscopically the lesions bear a close resemblance to tuberculosis. Erb suggests that the somewhat similar composition of the spores and the waxy capsule of the tubercle bacillus may be responsible for this. The spores contain "nearly 50 per cent of fatty oil."[5] It is this fat content which gives the spores their acid-fast characteristic. Erb very reasonably argues that this chemical composition influences the type of tissue reaction. He uses as an analogy the recent demonstration by Gardner and Cummings that the type of tissue response to silica particles is chemical rather than physical.

LITERATURE

The potential importance of lycopodium spores deposited in the tissues at operation can best be estimated by a review of the published cases. Erb and Antopol have each reported six cases. In this combined series of twelve cases, there have been three instances of intestinal obstruction due to very dense adhesions which the authors believe traceable to the lycopodium spores present. In one case an obstructing prostatic bar of lycopodium granuloma followed an operation for bladder stone. In another instance a draining sinus and granulomatous thickening, following an operation for traumatic hydrocele, led to an erroneous diagnosis of tuberculosis and subsequent orchidectomy. In one case nodules, appearing in the skin after removal of a benign tumor of the breast, led to a clinical diagnosis of carcinoma. Persistent draining sinuses have not been uncommon.

Lycopodium granuloma may be of little or great importance in a given case, depending upon the

* From the Stanford Surgical Service, San Francisco Hospital.

1 Lambert, quoted by W. G. MacCallum: "A Textbook of Pathology," p. 189. Second edition. W. B. Saunders Company, 1922.

2 Roth, Hans: Frankfürt Ztschr. f. Path. 29:59, 1923.

3 Antopol, William: Arch. Path., 16:326, 1933.

4 Erb, I. H.: Surg. Gynec. and Obst., Vol. 60, 1:40, 1935.

5 The Dispensatory of the United States 1926, twenty-first edition, p. 666.

situation and extent of the lesion. However, it is usually troublesome and may be dangerous. Since it can be easily avoided, steps should be taken to prevent its occurrence.

The etiology of lycopodium granuloma is obvious. All of the reported cases show symptoms which have persisted since previous operation. The spores have been identified in the tissues of these cases, and in most of them the use of lycopodium preparation of the gloves used in the operations has been established. (The one exception to this was a case of squamous cell carcinoma of the arm, reported by de Messer in 1901.[6] This patient presented an open lesion through which the spores were introduced by use as a dusting powder.)

REPORT OF CASE

A white farmer, aged fifty-six years, came under observation because of draining sinuses which had persisted for four months following the repair of a right, indirect inguinal hernia. Immediately after operation the wound gave evidence of primary healing, but began to discharge about the tenth postoperative day and continued to do so thereafter.

The wound was healed except for two small sinuses in the lower portion. These ran inward for about one inch and converged near the pubic spine. Surrounding the wound, and extending as far as the midline, was an area of induration. This involved the abdominal wall and the anterior portion of the abdominal cavity. It could not be felt by rectum.

The remainder of the physical examination was not remarkable. The pus from the sinuses showed staphylococci and cultured the Staphylococcus aureus. The patient was submitted to operation.

Operative Findings.—Very firm inflammatory mass involving the incision of hernioplasty, extending from Poupart's ligament to the midline and upward from the symphysis pubis for a distance of about three inches. In the lower portion of the scar were two small sinuses, the lowermost of which ran perpendicularly downward and the upper obliquely to the same point. The subcutaneous scar was wide and so dense that it was difficult to recognize the aponeurosis of the external oblique. The sinuses met at about the level of the external oblique fascia, where they were joined by a third sinus, which paralleled the full length of the incision but had no superficial opening. The common sinus then turned medial to the spermatic cord, which was buried beneath the fused aponeurosis of the external oblique and the conjoined tendon. It penetrated these layers and dropped into a localized abscess in the lower anterior portion of the abdominal cavity. This abscess contained thick pus in the amount of one or two ounces. The cavity was searched for a foreign body, but none was found. The pus was smeared and examined at the time of operation. This examination showed staphylococci and no evidence of fungus infection. Sections were sent for microscopic examination and culture. Culture of the pus gave a pure growth of Staphylococcus aureus.

Pathological Findings.—The sections of tissue removed showed typical lycopodium granuloma with areas of granulation tissue, dense scar, and necrosis. There was tubercle formation with many giant cells. Lycopodium spores were seen embedded in the granulation tissue and in the giant cells. With the Ziehl-Neelsen preparation, they proved to be acid-fast.

Subsequent communication with the surgeon who performed the operation for inguinal hernia gave the information that the gloves used at the time of operation had been prepared with lycopodium powder.

[6] de Messer, A. F.: Virchows Arch. f. Path. Anat. 163:111, 1901.

SUMMARY

1. The literature dealing with lycopodium granuloma is reviewed briefly.

2. The etiology and importance of lycopodium granuloma are discussed.

3. A case of lycopodium granuloma is presented.

CONCLUSION

The use of dusting powders containing lycopodium spores is hazardous, and should be discontinued.

490 Post Street.

PSYLLIUM SEEDS: INTESTINAL OBSTRUCTION

By Robbin E. Fisher, M.D.
Pomona

THE dangers inherent in the ingestion of some of the so-called bulk-producing foods or drugs are well illustrated by the following case:

REPORT OF CASE

Mrs. P. S., age seventy-four, was first seen the evening of May 24. Her complaints were cramp-like, abdominal pain, vomiting, and obstipation. Significant facts in the history were that her bowels had not moved for three days, that she had been taking one teaspoonful of whole psyllium seeds daily for the past month, and that she habitually ingested very little water or other fluids. Physical examination revealed a small, poorly nourished, elderly woman with a very thin-walled abdomen—quite markedly distended. A diagnosis of intestinal obstruction was made and the patient transferred to the hospital. Two enemas given were expelled with a moderate amount of constipated stool, and a small amount of gas without relief of symptoms. A flat x-ray plate showed a "stair-step" pattern of small intestines, and no distention or evidence of impaction of the colon. Laparotomy on May 25 disclosed a very much distended ileum, with an impaction producing almost complete obstruction, about ten inches proximal to the cecum. There were no pathological constrictions or adhesions of the ileum at its point of obstruction. The impaction had the characteristic feel of psyllium seeds. It was easily broken up and milked into the cecum. The abdomen was closed. The patient made an uneventful convalescence.

COMMENT

This case, as well as observations made at autopsies, lead me to believe that psyllium seed and similar bulk producers are dangerous substances, especially in elderly people, from the standpoint of intestinal obstruction or fecal impaction of the colon. Their widespread use should be discouraged by the profession.

338 Investment Building.

If the foes of human health are ever to be brought under subjection, health service must be put on a basis of organized preparedness, not only in state but also in local governments, with suitably trained forces in adequate numbers in every country or district of 25,000 population or over. Moreover, the public health forces must cease to be defensive only. They must take the offensive against the age-old entrenchments of disease and subnormal physical standards. A modern health service worthy of its name is militant, dynamic and constructive, rather than static. It is such a program that the Public Health Service has for many years been seeking to promote among the states and which has received a tremendous impetus through Title VI of the Social Security Act."—The Health Officer.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

TETANUS

SYMPTOMS AND DIAGNOSIS

Albert G. Bower, M.D. (6777 Hollywood Boulevard, Hollywood).—There appear to be two methods by which the toxins elaborated by Clostridium tetani are absorbed from their focal source to produce the symptoms characteristic of tetanus. In one instance, the toxins travel from the focus, where they are formed, directly to the central nervous system via the lymphatics of the nerve sheaths. In the other instance, observed especially in cases with short incubation periods, the toxins appear to be distributed to the muscles of the body through the blood stream, and then absorbed through the endplates of the motor nerves to travel up their lymphatics and reach the motor ganglia and central nervous system. There is both experimental and clinical evidence for each viewpoint. Once tetanus is definitely established, besides the original primary focus, there exists a true toxemia in addition to the effect on the central nervous system produced by the fixation of the tetanus toxins within the nerve cells for which they show a selective affinity.

Usually the incubation period is within eight to ten days. In massive infections with much necrotic tissue at the focal site, it may be shorter. In many instances it may be much longer, the bacilli apparently remaining latent in the tissues until subsequently activated by chemical or mechanical irritation.

The first symptoms are commonly a stiffness of the neck, the jaw muscles, the esophageal muscles, the abdomen, or one or more limbs.

This stiffness increases until sensory stimulation produces a tetanic spasm. Finally spasm becomes constant, the jaws are locked (trismus), and cannot be opened, the corners of the mouth being drawn out to present a fixed sardonic grin (risus sardonicus), the eyebrows are elevated and the forehead wrinkled. The voice is often changed. The eyes remain partially closed, and the head becomes retracted. Gradually the other muscles of the body become increasingly spastic, and opisthotonus or orthotonus may set in on sensory stimulation, producing frightful tonic convulsions accompanied by almost unbearable pain. Occasionally the body is bent to the side (pleurothotonus), and rarely even forward (emprosthotonus). These convulsions are reflex and may be set in motion by most trivial stimuli, *e. g.,* a ray of light striking the eye, a breeze from a fan, movement of the bed clothes, etc. The penis is affected along with the back muscles. In a well-defined case, complete relaxation between convulsions is lacking, the muscles remaining spastic to a lesser degree only, and voluntary movements are impossible of accomplishment. The muscles remain stiff when anesthesia is induced. Difficulty in swallowing and breathing are common, the latter being accompanied with cyanosis. Convulsions last from a few seconds to several minutes. Fever is not high as a rule, but may reach an agonal height of 113 degrees Fahrenheit. Profuse perspiration is commonly present. Death is usually from asphyxia or from exhaustion. It is practically never of cardiac origin.

It must be remembered, in connection with this discussion, that while typical tetanus is easy to diagnose from the above symptoms, mild or atypical tetanus exists, and may be very difficult to detect. Many cases of the disease start as localized tetanus, with pain or stiffness first detected around the atrium of infection, or limited to one limb. This may persist for a long time before trismus appears, and tetanus without trismus, its cardinal symptom, has been described. Such cases may recover spontaneously, the incubation period being very prolonged, the toxicity extremely low, and symptoms limited to a mild, general spasticity of the muscles, and a questionable trismus. We have seen such a case. About 10 per cent of all cases of generalized tetanus start as a premonitory localized type.

Considering the seriousness and fulminating course of the average case, it is surprising to note that, in a relatively large number of cases, the atrium of infection remains completely undisclosed.

Tetanus neonatorum usually occurs five to eight days after birth, most generally occurring from infection of the umbilical stump, but occasionally from circumcision. It is commonest in dairying communities, and is not unknown in California.

Diagnosis.—Given a typical case, the diagnosis is relatively easy. If trismus be present in characteristic fashion, the burden of proof rests upon any clinician, who diagnoses the case anything but tetanus. This does not imply that conditions simulating trismus do not exist.

Early diagnosis is of utmost importance from the standpoint of prognosis and treatment, for the earlier the treatment is started the greater is the probability of a successful outcome. Localized tetanus is apt to be overlooked, unless its occurrence is kept in mind and a history of the preliminary wound is obtainable. During the World War, nurses were required to invite the attention of medical officers to all cases in which tissues surrounding a wound were more rigid than around wounds in other areas on opposite sides. Experience taught that these cases usually developed generalized clinical tetanus, if adequate débridement and encircling infiltration with antitoxin were not promptly carried out.

The differential must be made between strychnin poisoning, tetany, rabies, meningitis, hysteria, and occasionally poliomyelitis, infectious myelitis, and sometimes the rarer nervous disorders.

Local conditions of the parotids and in the throat may also simulate trismus at times, but lack of the other signs of tetanus make these easily differentiated.

A careful history (when obtainable), a careful physical examination, a check of the deep and superficial reflexes, and the examination of the spinal fluid, when indicated, will serve to differentiate all of the above from tetanus relatively easily. In most of them trismus remains absent.

In strychnin poisoning, symptoms start immediately after assimilation of the drug in toxic doses. Complete relaxation usually occurs between the convulsions, and trismus is not a prominent symptom. Certain tonic pills used by the Mexicans, and surreptitiously swallowed by children for their sugar coating, cause this condition; and the same is true of the ordinary Hinkle pill.

In rabies the history of an animal bite, and the fear of water, with the lack of trismus, suffices. Do not forget that tetanus may follow a dog bite.

In tetany our patients are usually small children. The spasm is accompanied by a characteristic cry, and it is usually limited to the muscles of the larynx and extremities. There is no true opithotonus, or real trismus. Fever is low or absent, and stimulation of certain parts of the body does not produce convulsions.

In the other diseases of the central nervous system, the lack of trismus, the changes in the deep and superficial reflexes, the changes in the spinal fluid, and the variable and different response to different stimuli, should suffice to differentiate them.

* * *

PROPHYLAXIS

Elbridge J. Best, M.D. (384 Post Street, San Francisco).—The first step in planning the prophylaxis of a disease is to become familiar with its incidence and distribution. A survey of a recent yearly mortality report from the United States Census Bureau shows about one death from tetanus in 1,071 for the whole country. The highest rate is in cities of 2,500 to 10,000 population, and the lowest is in the rural areas. In dividing the nation into districts, the southern states show the highest incidence, with Florida averaging one in 312. Of interest is Kentucky with a rate of one in 839, much lower than the neighboring states. The midwestern states average about that of the nation as a whole. The coastal states have a lower rate. The State of Washington averages one in 8,000. Most of the states show the highest rate for tetanus in cities of 10,000 and over, the other states show the highest rate in cities of 2,500 to 10,000. In all the states the lowest rate was in the rural districts. California averages lower than the nation, and the large cities record most of the tetanus deaths.

The tetanus bacillus is found widespread in well-cultivated soils and in the intestinal tract of domestic animals. The incidence would supposedly be higher among farmers, gardeners, and stable workers; yet it is in the more congested centers of population that most infections are reported. To such areas prophylaxis should be more intensely applied.

One prophylactic effort has borne fruit, namely, the outlawing of firecrackers on the Fourth of July. The American Medical Association reports show the obvious results in the recent, almost no-tetanus mortality with the modern, sane Fourth.

Tetanus develops in punctured wounds and rarely in open wounds; therefore, theoretically, prophylaxis should be practiced immediately upon the receipt of each and every puncture wound. If every tetanus contaminated wound were débrided, cleaned, and oxygenated, nearly all patients would be saved.

For many years tetanus antitoxin has been administered by physicians and emergency hospitals more or less routinely when there was a suspicion a fresh wound was or might be infected by the bacillus of tetanus. Perusal of the United States Army medical records shows that the prophylactic use of tetanus antitoxin was practically universal in the American Expeditionary Forces. The soil of northern France is notoriously rich in tetanus possibility. With the use of serum, the incidence of tetanus infection was strikingly low. This result answered any doubt of the value of antitoxin as a prophylactic measure for tetanus.

The universal use of serum with every accidental wound raises a few serious questions. First, the cost of the serum would greatly raise the financial burden of treatment of wounds. Second, there is the serious problem of shock and death from serum reaction. Universal use of serum might result in serum deaths to an amount as formidable as the tetanus deaths it was supposed to prevent!

Descomby, in 1924, found it was possible to detoxify tetanus toxin, as Ramon had detoxified diphtheria toxin. Zoëller and Ramon had, in 1926, found a certain amount of tetanus antitoxin in the blood, after three doses of tetanus toxoid. This amount was not sufficient to protect an animal from infection, but if a fourth dose were given at the time of injury, protection was sufficient. Toxoid given in short intervals does not furnish as high blood antitoxin as two doses with long intervals (Bergey). In 1933, Ramon and Zoeller showed that, if two doses of toxoid are given thirty days apart and a third dose used at the time of injury, the blood antitoxin is higher than 1,500 units of antitoxin. Sneath and Kerslak, in 1935, showed no loss of antitoxin in the blood two years after active immunization with toxoid.

Ramon and Lematayer studied the presence of natural tetanus antitoxin in the blood of animals and man. In some animals they found antitoxin present, but there was no natural immunity in human serum.

Mixed vaccines have been studied since 1887. In 1926, Ramon and Zoeller found the antitoxin titer definitely augmented when tetanus toxoid was given in combination with diphtheria toxoid.

* Editor's note: This discussion was received May 20, 1937.

When one cubic centimeter of plain tetanus toxoid, improved, is injected subcutaneously, immunity slowly rises in the individual up to from ninety to one hundred and fifty days.

In recent years the French army has been used for prophylactic studies. Along with typhoid vaccine it is now obligatory that every soldier be immunized for tetanus. The present procedure is to give two cubic centimeters each of tetanus toxoid and diphtheria toxoid fifteen days apart. One year later one injection of two cubic centimeters each is given.

When tetanus antitoxin is given at the first treatment following an injury, immunity is present possibly for six weeks; but such immunity is not to be relied upon for more than two weeks.

It is of interest to note that a few nationally known biological houses offer tetanus toxoid, and one house has the combination of diphtheria toxoid and tetanus toxoid.

From the above résumé an up-to-date procedure can be set forth that, if carried out, will greatly lessen the present morbidity and mortality of tetanus infection.

Prophylaxis should be directed intensively toward those areas giving the higher incidence of the disease. Our census figures point, not to the agricultural areas, but rather to the centers of population, and those cities of 10,000 population and more need as much, if not more, protection than the cities of 2,500 to 10,000. A great work has been accomplished in these populated areas by the use of diphtheria toxoid. Therefore, it is proposed that the following procedure be carried out:

"For tetanus prophylaxis: All children be given one cubic centimeter of tetanus toxoid, with one cubic centimeter of diphtheria toxoid subcutaneously. Three months later a second injection is to be given. One year later, or upon receiving an injury, a third dose is to be given.

"As gardeners and soldiers are more exposed to tetanus infection than most other occupations, the same procedure should be carried out in these classes as is outlined for children.

"In cases of suspected wounds, when no previous immunity has been attempted, the following procedure should be carried out: Prompt débridement of the wound should be done. Oxygenation of the new open wound is then accomplished. Following this, an injection of 1,500 units of tetanus antitoxin (or tetanus-gas gangrene antitoxin) is given. At the same time tetanus-diphtheria toxoid is given (one cubic centimeter of each). Three months later a second toxoid injection is given. The third toxoid injection is to be given on receiving another injury."

* * *

TREATMENT

Hyman I. Vener, M.D. (Los Angeles City Health Department, 116 West Temple Street, Los Angeles).—The management of tetanus will be considered from the standpoint of: (1) the public health problem; (2) active prophylaxis; and (3) clinical treatment.

The Public Health Problem.—With the years, the problem of tetanus in California unfortunately has become a challenge to the medical profession. Between 1921-1935, there were one thousand cases, with a gross fatality of 75 per cent. The State Department of Public Health lists the incidence as follows: 1921-1925, there were 295 cases; 1926-1930, there were 347 cases; and for the period of 1931-1935 there were 358 cases. Los Angeles City and County contributed 414 cases, which is approximately 41 per cent of the entire series noted. During the same period the Los Angeles County Hospital treated 205 of these cases, with a gross fatality of 56.5 per cent.

Rapidity of development, the diversification of industry, agriculture and population, all may play rôles. Temperature and meteorological conditions in association with present unknown qualities of our soil may be contributory factors. In a previous study (Ref.: California and Western Medicine, 29: 6, December, 1933), approximately 53 per cent of the cases occurred under the age of ten years, the greatest incidence being between the ages of five and ten.

Have we chronic carriers, who only await the proper combination of circumstances to develop clinical manifestations? Do we possess antitoxic or immune properties to the disease, which are insufficient or lacking in the younger-age groups? Are there factors in methods of soil cultivation and agriculture which transmit subclinical infection over a period of years with resultant immunity? These and many more interesting speculations could be advanced, but these are problems for future research and consideration. One must not lose sight of the greater predominance of minor or trifling injuries in the age group of the population that is most likely to have the greatest number of these accidents. Furthermore, frequently such incidents occur under conditions and environment that are favorable for the multiplication of the organisms.

Under present circumstances, education presents the best method of approach to the problem. Parents should be advised of the consequences arising from apparently trifling and innocent injuries. The seriousness of the disease, once clinical manifestations have appeared, must be stressed. The methods of prevention must be emphasized.

The profession must also appreciate the foregoing facts, and particularly stress the point that the apparent innocence of an injury affords no criterion that clinical tetanus will not develop. The fact is apparent that not every case of a trifling splinter or abrasion receives prophylactic antitoxin. Nevertheless, such incidents may cause tetanus, and no one can forecast the ultimate result. The question is repeatedly asked, "Doctor, shall I give my child antitoxin every time he gets a splinter or scratches himself?" The answer is difficult to state. One may only present the possibilities and allow the final decision to rest with the patient or the parents.

Occasionally, the administration of 1,500 units of prophylactic antitoxin is inadequate, resulting

in a false sense of security. It may be possible that, in the future, previous immunization with tetanus toxoid may offer a solution. If the disease continues to increase, serious consideration may have to be given to such a program.

The coöperation between the official health organizations and the profession, as to this disease, has become a necessity. Our responsibility cannot be evaded as to the gravity of the situation.

Active Prophylaxis.—The tract of all puncture wounds should be incised, enlarged, properly cleansed, drained, and treated with hot compresses. Each wound must be treated as a potential infection. Every effort must be made to remove all foreign material. In deep abrasive wounds a thorough débridement should be performed. Prophylactic antitoxin should be given concurrently with surgical management.

Cauterization of wounds is mentioned, only to be condemned. Caustics form an eschar which excludes oxygen, thereby creating a favorable medium for anaerobic organisms. In addition to lowering the oxygen tension, additional insult is inflicted upon tissues already devitalized.

In the average case, 1,500 units of antitoxin generally is sufficient, regardless of the patient's age. Prior to administration, every effort should be made to obtain a careful history of previous allergic reactions, such as asthma, hay fever, or serum inoculations. These precautions should be supplemented by skin testing. When a positive history or skin test is obtained, the attending physician must make the final decision. He must weigh a potential case from the type of injury present, against the possible reactions resulting from the use of antitoxin. In place of a single dose, clinical experience has shown that acute serum reactions are less apt to occur if antitoxin is given in divided doses over a period of forty-five to sixty minutes.

In extensive injuries, 1,500 units of antitoxin can be given at once and repeated in twenty-four hours. However, when two doses are contemplated, it is not amiss to give only one dose of 3,000 units.

It must be reiterated that 1,500 units of antitoxin do not afford invariable protection.

Active Management.—The following discussion is the result of many modifications in therapy. Ten years of management and supervision of tetanus in the Communicable Disease Unit of the Los Angeles County Hospital makes one aware of the world-wide problem confronting workers in this field.

In the past two years, using the procedures to be enumerated, a series of fifty-five consecutive cases have been treated. Excluding deaths occurring within twenty-four hours of hospitalization, and cases treated elsewhere before admittance to the institution, there have been forty-four cases, with a net fatality of 13.6 per cent. This rate is believed to be the lowest reported in medical literature, and this discussion will serve as a preliminary report. The fact that the number of cases is relatively small is appreciated, but the program is being continued.*

Every case of tetanus is a grave emergency, and no time may be lost in instituting treatment, regardless of how mild the case may appear.

Hypothetical Case.—To avoid confusion, and for the sake of brevity and conciseness, a hypothetical case will be chosen and its course followed during the first few days in the hospital. All the hours enumerated are arbitrary, unless otherwise definitely specified.

1. Patient admitted to diagnostic ward—8 a. m.

History obtained from patient or party accompanying him. Physical examination performed with minimum disturbance of the patient. Diagnosis is made. The focus of infection is determined and isolated. A skin test is performed.

2. Sedatives administered—8:30 a.m.

Ten to thirty grains of chloral hydrate are dissolved in one-half to one ounce of water, depending on the age and size of the patient. It is given by mouth, if patient can swallow, otherwise by rectum. Deep narcosis should be avoided, due to adverse changes that may result from the arrest of metabolism.

Subsequently, while the patient is in the hospital, chloral hydrate alone, or in combination with calcium bromid, 20 to 50 grains—depending on the age and size of the patient—may be given. The dose is repeated as needed, orally or by rectum. Mild seizures are not an indication for additional sedatives. It is only occasionally that the use of other commercial sedatives have to be added.

After the sedative is administered, an interval of one hour elapses before treatment of any kind is instituted.

3. Local treatment of the wound—9:45 a.m.

If necessary the focus is encircled with novocain, otherwise this procedure is omitted and 20,000 units of tetanus antitoxin is injected in an encircling manner about the lesion. After a waiting period of approximately forty-five minutes, or at 10:30 a. m., the lesion is incised widely, or excised thoroughly, whichever is applicable. All foreign material is eradicated, and the lesion treated with hot compresses, regardless of how innocent it may appear. Care should be taken to keep the incision within the area encircled by the antitoxin. It is possible that a temporary barrier against further progress of the tetanus toxin into the general circulation may be formed by such a procedure.

If an extremity be involved, as is frequently the case, 40,000 additional units is injected deep intramuscularly, at the junction of the upper and middle thirds in a manner to girdle the thigh. This procedure establishes an additional barrier to the spread of the toxin along the course of the nerve trunks.

4. Cisternal therapy—11 a. m.

If sedation is sufficient, no great difficulty is encountered with this procedure. Drainage of

*To September 1, sixty-two cases. Excluding eight deaths occurring within twenty-four hours of hospitalization, fifty-four cases with eight deaths, a net fatality case rate of 14.8 per cent.

spinal fluid is followed by reinjecting 20,000 units of antitoxin slowly by the gravity method. The serum must previously have been warmed in a lukewarm bath, to body temperature.

Following cisternal therapy, the patient's temperature may be elevated from 104 to 105 degrees Fahrenheit, but this gradually subsides in six to eight hours. During this period hourly rectal readings should be charted. When the temperature has receded to approximately 101 or 101.5 degrees Fahrenheit, intravenous antitoxin is administered.

5. Initial intravenous antitoxin administration—7 p. m.

Approximately six to eight hours after the cisternal procedure, the first intravenous dose of 40,000 units is given. This is diluted in 300 to 500 cubic centimeters of normal saline, regardless of age or size of the patient. About one hour should be allowed for the intravenous flow. The rate must be slow and by the gravity method. Five minims of adrenalin are given hypodermically at the beginning, midway, and at the completion of the antitoxin injection.

Precautions against anaphylactic shock should be observed. It is advisable to keep all serums used at room temperature for twenty-four hours before giving. Prior to immediate use these vials should be immersed in a lukewarm solution for fifteen to twenty minutes. Always warm the antitoxin before giving, regardless of the route employed.

6. Hexamethylenamin therapy—10 p. m.

This drug constitutes a very important and essential part in therapeutic management. Two hours following completion of the intravenous antitoxin (as noted in procedure 5) 15 grains of hexamethylenamin (10 cubic centimeters of a 10 per cent solution) are given intravenously.

7. Second intravenous antitoxin administration—11 p. m.

At the end of one hour, following the hexamethylenamin, an additional 40,000 units are given, provided there has been no reaction from the initial intravenous dose (procedure 5), and the rectal temperature remains below 102 degrees Fahrenheit. This is prepared as before, and all previously mentioned precautions are observed.

If a serum reaction has occurred, no further intravenous antitoxin is given. When an elevation in temperature is the sole reaction, additional intravenous antitoxin is withheld until it subsides, despite the appreciable increase in the time interval between doses.

8. Subsequent intramuscular antitoxin—7 a. m. or near the end of the first twenty-four hours of hospitalization.

Approximately eight hours after the second intravenous antitoxin injection (procedure 7), an additional 40,000 units is injected deep intramuscularly in an encircling manner. This injection should be proximal to the atrium, as already described.

If, however, for any reason, the second intravenous dose of antitoxin (procedure 7) is omitted, intramuscular injections are substituted as follows:

Eight to twelve hours following the initial intravenous dose of antitoxin (procedure 5), 40,000 units is given. This dose is repeated in eight to twelve hours. All intramuscular injections are given deep, and in an encircling manner, until an aggregate minimum of 200,000 units has been administered. No further antitoxin is given in most cases.

Hexamethylenamin, fifteen grains (ten cubic centimeters of a 10 per cent solution) is given intravenously ten to twelve hours after each intramuscular injection.

A summary of the dosage is as follows:

20,000 units infiltrated to enclose the lesion in its center.

40,000 units deep intramuscularly to circle the limb proximal to the focus.

20,000 units intracisternally.

40,000 units intravenously in normal saline, approximately eight hours following the cisternal.

15 grains of hexamethylenamin intravenously, two hours after the intravenous antitoxin.

40,000 units of antitoxin in normal saline intravenously, one hour after the administration of the hexamethylenamin, provided no previous reaction has occurred.

40,000 units of antitoxin deep intramuscularly to circle the limb proximal to the lesion, eight hours after the second intravenous antitoxin, and followed by:

15 grains of hexamethylenamin intravenously in ten to twelve hours.

Total dosage, 200,000 units of antitoxin regardless of size, age or sex of the patient, or the incubation period.

If any reaction occurs following the initial intravenous antitoxin, all further intravenous antitoxin is omitted. Instead, intramuscular injections of 40,000 units are substituted, until a total of 200,000 units has been administered. Each intramuscular injection is supplemented in ten to twelve hours by 15 grains of hexamethylenamin intravenously.

Desensitization Measures

After the minimum amount of antitoxin has been given, the progress of the patient is observed. During the first ten to twelve days the rigidity of the neck, the board-like tenseness of the abdomen, and trismus all remain. However, the general condition of the patient continues to show clinical improvement.

After once giving 200,000 units, additional large doses of antitoxin are not given unless the patient has a relapse. However, 1,500 units are given intramuscularly every three to four days for at least four doses in order to keep the patient desensitized in case more antitoxin be needed later.

Occasionally, when convalescing, orthopedic conditions arise which require surgical interference. If this be the case, it is advisable to continue at intervals the prophylactic injection of 1,500 units intramuscularly. This should be given every four or five days, until the end of the second week of surgical convalescence. Cases of relapse have been observed when such precautions were omitted.

Special Considerations

Fluids.—The patient should be allowed all the fluids he can take by mouth, if distress is not too great. If unable to swallow, 5 per cent dextrose, saline, or a combination of the two, may be given intravenously during the first few days. Caution must be exercised not to overload the patient with intravenous fluids. Massive doses are dangerous and may induce pulmonary edema, hypostatic pneumonia, and cardiac failure. After the first few days, with assistance, most patients manage to take small amounts of water by mouth.

Oral Hygiene.—Oral sepsis must be prevented, as far as possible, by gentle suction, aspiration, or cleansing. Careful attention to this detail will help avoid a fatal secondary aspiration pneumonia.

Diet.—The diet consists of liquid foods at frequent intervals, gradually changing to a semi-soft and soft diet by the end of the second week.

Posture.—Frequent change of position is essential to avoid pulmonary complications. Resting on the side or abdomen is preferable and desirable by most patients. A certain degree of restlessness or mild convulsions are of no great concern, and are no indication for additional sedation.

Sinuses. — Despite precautions, patients frequently develop purulent sinusitis. Excessive sedation and poor oral hygiene, associated with mouth breathing and rapid shallow respirations, contribute to a secondary bronchopneumonia.

To avoid such complications, postural drainage by moderate elevation of foot of the bed, and shrinkage of the mucous membrane of the nose, will aid materially.

Pneumonia.—This condition may complicate the clinical picture between the fifth and seventh days, and requires symptomatic treatment.

Serum Sickness and Urticaria.—This complication almost invariably occurs between the fifth and tenth days. Drugs used in the treatment are: ephedrin, aspirin, calcium bromid, and calamin lotion. Tincture of Apis, 10 to 60 minims, four times a day, is often of great aid. Occasionally, calcium gluconate is used intravenously. If the discomfort of the patient becomes too great, sedatives or narcotics may be necessary.

Quiet.—The patient should be in a semi-dark room where excessive light can be avoided. Special attention should be given to squeaky beds, doors, noisy elevators, unnecessary bedside conversation, and repairs being made in the hospital, in the vicinity of the patient's room. Such factors must be reduced to a minimum, for they serve as harmful stimuli.

Nursing Management.—Next to antitoxin therapy, general nursing care plays the most important rôle. The nurse should be entirely aware of the difficulties encountered and their management.

Frequent attention to oral prophylaxis, posture, changes of position and other factors enumerated, all contribute to recovery. The nurse should refrain from fussing too much with the patient.

Good judgment and an appreciation of practical management will often be the deciding factor in saving life.

In conclusion, the problems confronting the profession in the field of prevention and prophylaxis are stressed. An effort has been made to present the difficulties encountered, and the practical application of certain tried principles in management which, at this writing, have resulted in the lowest-known fatality in medical literature for such a series.

Simple Cysts of the Ovary.—Stabler selected ninety-three patients for his discussion because their symptoms seemed to relate directly to the ovary, both preoperatively and postoperatively. Follicular, luteum and retention cysts were generally the rule. All the patients had cystic ovaries that were diagnosed at the time of operation. Two symptoms were common to all cases: a boring type of pain in one or both sides and an increase of pain at menstruation, of a bearing down type. Fifty-five patients had pain in the back, fifty-three had pain down the leg, fifty-eight had regular menstruation, twenty-three had irregular menstruation and thirty-seven had to go to bed because of pain at the menstrual period. His treatment was the resection of the ovary, removing all cystic tissue if as much as one-sixth of the ovarian tissue could be left; removal of the entire ovary if the whole ovary was cystic; puncture of the cysts when only a few cysts were found. In all patients, when it was deemed advisable, who were more than thirty-six years of age, the entire ovary was removed if it were cystic, both ovaries if both ovaries were cystic. Postoperative results, which range from six years to four months, show freedom from pain in forty-seven cases, pain after operation that corresponded to the resected ovary in thirty-two cases, pain after operation that corresponded to the removed ovary in fifteen cases, and pain after operation believed to be due directly to the remaining ovarian tissue in twenty-three cases. The regularity of menstruation improved in thirty-three cases, menstruation was unimproved in seventeen cases, the menstrual cycle was shorter and the flow more moderate in sixty cases, forty-one patients were apparently improved and five were apparently unimproved. Recognition of, or the failure to recognize, the clinical importance of multiple follicular, luteum or retention cysts of the ovary may result in the success or failure of a major surgical procedure as far as the clinical results to the patient are concerned.—*Alabama Medical Association Journal.*

Malignant Tumors of Nasopharynx.—Needles presents a study of thirty-five cases of malignant tumors of the nasopharynx, sixteen of which manifested neurologic complications. Patients with disturbances of the auditory mechanism—whether tinnitus, deafness, pain or stuffiness in the region of the ear—should be subjected in a routine manner to a nasopharyngeal examination. Likewise, in the presence of enlargement of the cervical lymph nodes the possibility of a nasopharyngeal growth should be entertained as regularly as is tuberculous adenitis, the luekemias or Hodgkin's disease. For the neurologist, the presence of a basilar syndrome, especially with involvement of the cranial nerves coursing through the middle fossa, should immediately lead to the request for a nasopharyngeal examination. A basilar meningioma, a metastatic neoplasm, an inflammatory process or an aneurysm at the base of the brain can produce an identical neurologic picture; the differential diagnosis may therefore hinge on this simple diagnostic procedure. When, finally, in addition to the auditory symptoms there is enlargement of the cervical glands and involvement of the cranial nerves at the base of the brain, an irrevocable syndrome of nasopharyngeal malignant tumor is present. The results obtained from radiotherapy in cases of nasopharyngeal tumor are encouraging but as yet far from satisfactory. Earlier diagnosis and treatment may be the instrumental factor in correcting this defect. In cases which clinically present the picture of malignant tumor of the nasopharynx it is well to disregard a negative biopsy report and to proceed with appropriate radiotherapeutic measures.—*Journal of Nervous and Mental Disease.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

HOWARD MORROW.....President
WILLIAM W. ROBLEE.....President-Elect
LOWELL S. GOIN.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

OFFICIAL BUSINESS

AMENDMENT TO CONSTITUTION—ELECTION OF COUNCILORS

In accordance with the rules of the House of Delegates, the following proposed amendment, introduced in Del Monte, to the Constitution is given its second publication and notice.

(*d*) Amendment to Constitution, Article VII, Section 1—Election of Councilors. Introduced by Dr. Loren R. Chandler of San Francisco.

(d) *Resolution Regarding Nomination and Election of District Councilors*

RESOLVED, That Section 1 of Article VII of the Constitution of this Association be and hereby is amended as follows, by striking out all the third paragraph of said Section 1 of Article VII, reading as follows:

"The nine district councilors shall be elected as follows: Prior to the time set for the election of district councilors the delegates of each councilor district for which a councilorship is about to become vacant, shall meet, organize, and in due form elect one or more members of the said councilor district as the nominee or nominees for the said vacancy. Such nomination or nominations shall be submitted in writing, signed by at least two delegates who were present at such meeting, and shall be given to the Secretary-Treasurer, by him to be transmitted to the House of Delegates. The House of Delegates may make additional nominations from the floor of the House, and in the event that the delegates from a councilor district fail to submit a nomination or nominations, shall on its own account proceed to make nominations for each district councilor vacancy. A vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship"; and by inserting in lieu thereof the following:

The nine district councilors shall be elected as follows: At least one month prior to the time set for the election of district Councilors, the Secretary-Treasurer shall mail a written notice to each delegate, addressed to his address listed in the Association's records, of each councilor district for which a councilorship is about to become vacant, notifying the delegates of the time, which must be at least two weeks after the mailing of the notices, and a place designated by the Secretary-Treasurer, for the nomination meeting of the delegates of said councilor district.

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Passing Comment.*
2. *Medical Functions of State Board of Public Health.*
3. *Public Good Will.*
4. *Silent Audiences.*
5. *Two Responses.*
6. *Association Nights.*
7. *Pacific Coast Conference.*
8. *Your Advertising Friends.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Public Meetings.*
2. *Accidents on Farms.*
3. *Hospital Insurance.*
4. *Nurses' Unions.*

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

PASSING COMMENT

Write to the Manager, Hotel Huntington, Pasadena, for your hotel reservations for our annual session, May 9 to 12. All reservations are made through the hotel management. The official program will appear in the April issue. Plan now to attend.

* * *

Barking dogs, singly or in small packs, cannot halt the progress of the caravan of medicine. Invariably these barking groups become lost in the quagmires of their nebulous theories relating to socio-economic experimentations, which are unwarranted and of scant or any merit.

* * *

Better check and see if you have a 1938 American Medical Association Fellowship card in your pocket or files. You will need it to gain admission to the meetings and exhibits of the American Medical Association session in San Francisco next June.

* * *

You undermine yourself, your future and your profession when you agree to render service at "cut rates" and below the accepted fees for your community. You are digging your own professional grave when you fall for the blarney of some claim agent or adjuster. Your private patients will desert you when you bill them at higher rates than those you accept from an insurance company. You may think they won't, but they certainly will find out and then they will not seek your services. Adhere to one standard—just, fair fees for all—private patients and insurance companies. Refuse to undercut fees.

* * *

Income tax, state and federal, payment time is at hand. Do not forget to file your returns. Remember also that you are entitled to allowance for expenses of medical organization dues, JOURNAL subscription, expenses while attending medical meetings, funds contributed to charity, depreciation on office equipment, library, and automobile. It pays to have a competent person compute your returns and conserve your interests. There is a penalty for neglect or delay in filing. Attend to it before the penalty date becomes effective.

* * *

With almost every malpractice suit falling into the class of "blackmail" or "hold-up" and without basic merit, the filing of a suit against a doctor is rarely a reflection upon his professional reputation. Therefore, the doctor need not be greatly concerned except for the annoyance and time required for defense in court.

In spite of these facts, a doctor sued becomes alarmed and is anxious that his insurance carrier make a cash settlement in place of defending him in court. This is an ill-advised attitude. Settlement will arouse suspicion in your community and the whisper will go about, "Dr. ——— must have been neglectful, for he made a cash settlement out of court."

In place of settlement, fight and carry the case through to a court verdict. Vindication by a verdict of "No cause for action" will be to your credit in your community. Just recently a case was defended in court where the amount requested for settlement was $6,000. When the jury rendered its verdict, "No cause for action," the doctor was vindicated; the patient and his attorney were out $6,000, to which they were not entitled.

Another case that went to trial after several weeks a verdict was brought in by the jury in favor of the plaintiff. Argument by counsel obtained a new trial. The plaintiff and attorney were unable to finance a new trial—consequently, the case was dismissed. It is reasonable to presume this attorney will be reluctant to accept future cases unless he has definite proof to substantiate a claim.

When attorneys perceive that suits are going to be fought and that their drafting of a declaration is not going to be followed by an offer of cash settlement out of court, the number of these suits will decrease. Hence the advice: while a suit is unwanted and unwelcome, should you be made a defendant do not assent to or seek settlement. Fight it through the courts to the very limit. Do not compromise yourself.

MEDICAL FUNCTIONS OF STATE BOARD OF PUBLIC HEALTH

From time to time inquiries are received as to what extent the Department of Public Health engages in the practice of medicine. In order that official activities might be accurately recorded, Doctor Dickie, State Director, was requested to supply this information. He kindly complied by sending the following statement:

PUBLIC HEALTH OF CALIFORNIA IN 1937

Walter M. Dickie, M.D.

Director, California State Department of Public Health

One of the most far-reaching activities in the promotion of public health established during 1937 is the reëstablishment of the Bureau of Venereal Diseases in the California State Department of Public Health. In 1917 the first state bureau of this sort was established in California. It operated until 1920, when lack of funds stopped its work.

The Bureau of Venereal Diseases, established by the 1937 legislature, has a biennial appropriation of $150,000, augmented by Social Security funds. The program in the control of the venereal diseases provides for case finding, treatment, support for public clinics, free distribution of drugs for patients who are unable to pay, education in prevention and other attributes that may be effective in the control of these diseases. New forms for reporting cases of syphilis have been devised and circular letters pertaining to reporting, treatment, and control have been sent at regular intervals to all licensed doctors of medicine in California.

The extensive migration of agricultural laborers into California from other states and from Mexico has made necessary the establishment of special activities to control communicable diseases among such laborers, and to provide essential protection to residents of California. These activities have covered general camp sanitation, immunization against smallpox and diphtheria, instruction in child hygiene, maternal welfare, and nutrition. In addition, special facilities for the diagnosis of tuberculosis have been provided. A motor truck, equipped with x-ray apparatus, is moved from camp to camp, and all reactors to the tuberculin test are given the x-ray examination.

Six pediatricians have been added to the staff of the Bureau of Child Hygiene and have been assigned to regular routes in the extreme rural districts of the State, where medical services are generally not available. Two trailers, equipped with dental apparatus, have been sent into the extreme rural districts, where three staff dentists provide temporary repairs for children whose parents are unable to pay for such repairs. Educational activities in dental hygiene are carried on by a nutritionist and dental hygienist. During the year three new full-time county health units have been added to the seventeen such units that existed in California prior to this year. The new units are in Yolo, Santa Cruz, and Ventura counties. The following counties of California now provide a full-time health service for their residents: Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Madera, Monterey, Orange, Riverside, San Bernardino, San Diego, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Stanislaus, Ventura, and Yolo.

Because of the various hazards connected with many industries of the State, it has been necessary to establish active operations in preventing such hazards. Various dusts, chemicals and air pollution are factors in the production of industrial diseases. Surveys have been undertaken in the various industries and coöperative efforts with manufacturers have been developed in order to lessen the industrial hazards and thereby prevent the production of industrial diseases. A special study of carbon monoxid poisoning in transportation is now under way.

Since 1927, when the so-called Crippled Child Act became effective in California, the State Department of Public Health has maintained clinics, as required by law, in an effort to learn of physically handicapped children who might secure treatment under the provisions of the Act. Through Social Security funds, activities to discover crippled children have increased, and no less than thirteen clinics have been conducted in California during 1937 for this purpose. Since the so-called Crippled Child Act became effective in 1927, more than one thousand physically handicapped children have received treatment through the provisions of the Act.

Communicable diseases have provided no particular problems in control during the year. Influenza of a severe type was prevalent during the early part of 1937, but no extensive outbreak prevailed.

General health conditions throughout the State have been good, and the coöperation of the medical profession in meeting the requirements of public health laws has constituted an important factor in the maintenance of a satisfactory record in 1937.

PUBLIC GOOD WILL

Sound public opinion in regard to the great question of public and private health! Public confidence and good will toward scientific medicine! These are the quests of our Association, its county societies, and the individual member. To acquire them, to retain them, and to cause their influence and power to be exercised continuously, demands that every opportunity and occasion be embraced to establish this public sentiment in the minds of the people and those who hold public office.

During 1938 and 1939, this is a major purpose of our Association. Every member should contribute of his time and efforts to bring about realization. To that purpose and end it is advised that every county unit and member participate along the following lines:

1. On every occasion offered seek to explain the purposes of organized medicine.
2. Impart information as to the truths of scientific medicine, what it has and holds for the individual's health welfare in contradistinction to the claims and unscientific representations of the cults and manufacturers of proprietary preparations. Educate your patients and friends.
3. Enlighten people in regard to preventive medicine and indicate how its application will prevent unnecessary illnesses. Point out the value of periodic physical examinations, and when conducting them do so in a meticulous and thorough manner.
4. Join with every community health movement, lend it your support and guide it along safe and sound channels.
5. Embrace every opportunity to address lay groups in their meetings upon some health or medical subject and teach them to seek advice from competent medical men.
6. Proffer advice and coöperation to local officials and legislators. Present them with facts and endeavor to help them in finding sound solutions for the health needs of the community and the State.

These are a few of the major means whereby you can develop and maintain public confidence and good will. Every day, if you are alert, you will find occasions to disseminate dependable knowledge. It is the aggregate total of these contacts and efforts that will eventuate in a better public understanding, and your interest and effort added to those of six thousand fellow members are bound to produce results evidenced in an understanding public that will be sympathetic and will lend support in the suppression of those who seek to mislead and deceive.

A great opportunity presents. Will you embrace it?

SILENT AUDIENCES

Editors and those responsible for copy in publications ponder through many an hour in their earnest endeavor to present readers with discussions and comments that are of interest, informative, and helpful. One batch of copy for a given issue is barely completed when the time is at hand for the preparation of copy for the next issue—press deadlines must be conformed to and cannot be ignored.

These writers have their hours and moments of reflection and conjecture. Having prepared copy for several issues with every care and consideration, receiving no comment or inquiry for weeks or months; having invited suggestions and response and receiving none in return—well, the writer is prone to ponder and wonder as to his silent audience of readers. Is he maintaining interest, are his articles helpful, are suggestions being followed? These questions come to his mind in his moments of retrospection. As a rule he has no answer. He must continue the preparation of articles for following issues upon his own initiative, inspiration, and enthusiasm. That is his task.

Sometimes he is tempted to write an item that is palpably inconsistent with facts just to see if he will receive a flood of letters in protest. To yield to such temptation would be most unwise, for confidence might be lost and a tempest in a teapot result.

The thought behind this general comment is that if readers would from time to time proffer suggestions as to subjects, these reading pages might be made more interesting and helpful. If a subject occurs to you, may we not receive your suggestion?

TWO RESPONSES

The score still remains "two responses" to the several suggestions and requests that one thousand members subscribe $100 each to create the nucleus for a permanent Association Endowment Fund. Probably these items have been overlooked in previous issues, therefore the suggestion is being repeated.

A permanent endowment fund, the principal sum to remain intact for all time, will provide an annual interest income that will enable the Association to expand its functions and attain greater ends for the benefit of the members and the public.

There are one thousand members, it is felt, who could contribute $100 or more to such a fund and make possible this yearly increase in income. Will they respond? Personal solicitation is not possible, hence the appeal can be made only through these columns. Will you respond? Your check this month will be most acceptable.

ASSOCIATION NIGHTS

A fine group of members of Santa Barbara and Ventura County Societies greeted President-Elect W. W. Roblee, Councilor Louis A. Packard, and State Secretary Warnshuis at an Association night on February 7. The meeting was held in the auditorium of the Cottage Hospital in Santa Barbara.

On the night of February 8, ninety per cent of the membership of San Luis Obispo County Medical Society held a special meeting that was attended by these three State officers.

At both meetings there was a discussion of state and county activities, concluding with a round-table of questions and answers. An excellent spirit prevails in these three counties.

PACIFIC COAST CONFERENCE

Upon invitations extended by the Committee on Public Relations, officers of the Oregon and Washington State Medical Societies have consented to send representatives to a conference to be held in San Francisco on Sunday, February 27. The meeting will be held in the Sir Francis Drake Hotel.

California, Washington, and Oregon have common problems related to medical services and legislation. It is felt that a general discussion as to their nature and scope would eventuate in the formulation of common policies and should be productive of mutual benefits to all three organizations and their members. By unity of purpose and action it is also felt that wholesome results will evidence themselves in a better understanding and attitude on the part of the public and that legislatures may be enlightened in regard to proposed legislation.

Our three Pacific Coast medical organizations can be helpful to each other, and through joint effort can record greater service. In a subsequent issue a summary of the conference's deliberations will be imparted to our members.

YOUR ADVERTISING FRIENDS

In each issue members will find the advertisements of business firms who are their friends. These firms desire to serve you efficiently and to your satisfaction. They may be relied upon to deal with you honestly and fairly. They will be most helpful in assisting you to acquire supplies or equipment most advantageously.

As patrons of your official journal, they merit first consideration and preference, other things being equal. The Council respectfully requests that you subscribe this support and so aid in retaining these advertising patrons. You will also be rendering a service if you advise detail men and salesmen that you prefer dealing with your friends who employ space in your JOURNAL.

Read the advertising sections of each issue and write to these advertisers. You will find many interesting and informative reading items in these sections in addition to the advertisements. Please be helpful in retaining this income revenue. Thanks.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Public Meetings

Education of the public is an important function of every county society. To that end county societies should sponsor public meetings at which informative talks on medicine and medical care are given. Counties having Woman's Auxiliaries will find the Auxiliary of tremendous assistance in arranging details and creating local interest and attendance. Lay organizations can also be interested and caused to join in the sponsorship of public meetings.

Competent speakers can be enlisted from your membership or from the membership at large. Careful thought should be given to the selection of subjects and the manner of their presentation. They must be of general interest and personal application, definitely instructive and informative, and presented in a manner to hold interest and obtain support.

All of which means work, thought, and time. However, such meetings will produce satisfactory returns, beget public confidence, and advance community interest. The efforts expended are well worth while, and every county society should engage in this activity. Presidents and secretaries will do well to bring this phase of society activity to the attention of their members at the next county meeting. Initiate a program and cause a special committee to direct this educational project.

Accidents on Farms*

When a farmer buys an industrial product, he pays for the cost of the industrial injuries involved in the production of that particular object. When the farmer sells his products, he must receive as a part of his selling price the costs of the accidents which have occurred in connection with the raising and marketing of his product.

It is estimated that the annual cost of industrial agricultural accidents in California is $10,000,000.

During the years 1932-1936, inclusive, there were 252 persons killed, and 45,095 employees injured in California agriculture.

It has been stated that in Kansas, in 1934, more than 50 per cent of the occupational deaths in the state occurred on the farms.

It is estimated that the farm fire losses in the United States are $100,000,000 a year and that there are 3,500 lives lost in these fires.

Since the use of electricity, liquefied petroleum gases, farm machinery, and automotive vehicles, has become common on the farms, the deaths from these uses have increased enormously.

Ladders, hand tools, infections and falls from various causes are largely responsible for the great number of injuries and deaths in which machinery takes no part.

The agricultural industry in California has, for a number of years, reported to the Industrial Accident Commission a greater number of injuries to employees than any one other industrial group. These reports do not include the accidents that occur to the farmers or their families; they are not classed as employees.

There is no agency connected with the agricultural industry that can afford to omit accident prevention from its program. They should analyze the accidents as to their cause and effect, and then remove the causes. Every such organization should also stress the necessity for proper training in the care and handling of injuries and injured persons.

Agriculture, if it so desires, can make as good a record as the other industries have made.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

* Reprinted from the Bulletin of the California Industrial Accident Commission.

Hospital Insurance

The Council and the Committee on Public Relations have endorsed the following hospital insurance organizations:

1. Insurance Association of Approved Hospitals, operating in San Francisco Bay regions.
2. Associated Hospital Service of Southern California.
3. Intercoast Hospitalization Association of Sacramento.

Members will do well to urge groups in their respective committees to obtain this form of hospital insurance protection.

Nurses' Unions

The appended correspondence is informative upon the subject of unionization of nurses. The attitude of the Nurses' Association is commendable and will no doubt receive the approval of physicians and surgeons. It is inconceivable that any nurse at all conversant with the history of her profession, its background and traditions of service and humanitarianism, would desert that glorious record. To repudiate her profession and calling and accept instead the classification as a labor trade-union is to relinquish ideals, and sets up a background of commercialism. Every nurse may well give thought as to what such a decision entails as to her future and the future of her profession.

(COPY)

THE CALIFORNIA STATE NURSES' ASSOCIATION, INC.

San Francisco, February 3, 1938.

Dear Doctor Warnshuis:

In reply to your letter of February 1, we are enclosing a formal statement from the American Nurses' Association in relation to unions which determines the policy of this Association.

We know of one nurses' union, Local 19923, which is established in San Francisco, Room 414, Grant Building.

We understand that nurses are being threatened with loss of employment in connection with care of union patients. You will find enclosed a copy of a resolution passed by unions at Long Beach. Other material has been issued and we will send you copies if you wish.

Efforts are also being made by the union to influence student nurses at time of graduation. The Association is anxious in every way to combat the influence of unions. We find, however, that certain conditions exist in many hospitals which give the unions ground to state that they can give nurses support in correcting these conditions. Hospitals should make every effort to improve these conditions to remove what is often just cause for complaint.

The Placement Service Committee is formulating standards for nursing personnel employed in hospitals. Only a few hospitals have given consideration to correction of the practices which are the source of grievance to their personnel.

It is regrettable that these conditions persist and give the union an opportunity to suggest that they can help to improve such.

609 Sutter Street.

Sincerely yours,

(Signed) HARRIOTT L. P. FRIEND,
Director at Headquarters.

* * *

(COPY)

AMERICAN NURSES' ASSOCIATION

New York, June 8, 1937.

Dear State President:

Inasmuch as nurses throughout the country are being approached and requested to join unions, a Committee to Study the Question of Unions for Nurses was appointed by the Board of Directors of the American Nurses' Association at its meeting held on Thursday afternoon, January 28, 1937.

As a result of the work of this committee, the Board of Directors of the American Nurses' Association has taken the following position:

1. Before allying herself with any recently organized groups, the individual nurse should ask what these new organizations can do for her and for the profession of nursing as compared with the services which her professional organizations have rendered, continue to render, and which they will be on the alert to develop for nursing and for the nurse as need for them arises in the future.

2. The Board of Directors of the American Nurses' Association, through its committee to study unions, has prepared a statement describing what the American Nurses' Association has done and will continue to do to assist the individual nurse and to promote effective nursing service for the public. It is urged that this statement be called to the attention of all of the members of your State Nurses' Association.

3. The American Nurses' Association stands for the fulfillment of all professional obligations.

4. The American Nurses' Association does not at this time recommend nurse membership in unions.

50 West Fiftieth Street.

Very sincerely yours,

(Signed) HELEN TEAL, R. N.,
Secretary.

* * *

EMPLOYMENT OF UNION MEMBERS AS NURSES

Proposition No. 40, presented by H. C. Woods of Nurses' Union No. 19923 of San Francisco.*

WHEREAS, The Nurses' Union of San Francisco, Local No. 19923, is a new, and as yet not very strong one; and

WHEREAS, It is difficult to organize nurses because of the general anti-trade union attitude of the hospital authorities and the State and County Nurses' Associations; therefore be it

Resolved, That the Nurses' Union of San Francisco, Local No. 19923, goes on record as requesting all trade-unionists, when hiring a graduate nurse, to demand that they be given one who is a member of some local of the Nurses' Union; and be it further

Resolved, That our delegate to the Central Labor Council be instructed to submit this resolution to that body for concurrence; and be it further

Resolved, That our delegate to the State Federation of Labor Convention, also, be instructed to introduce this resolution for the concurrence of that body.

COMPONENT COUNTY MEDICAL SOCIETIES

KERN COUNTY

The Kern County Medical Society met at the Mercy Hospital in Bakersfield on Thursday evening, January 20. Dr. Harry W. Lange, newly elected president, called the meeting to order.

Dr. L. A. Packard discussed further plans for the postgraduate conference to be held at Santa Barbara on March 12 and 13. Members were requested to submit topics for discussion to the local committee, consisting of Doctors Packard, William Moore, and Eric F. Colby.

The Committee on Obituaries offered obituaries on the deaths of Dr. George O. H. Buchner and Dr. J. E. Veon. Copies were ordered to be placed on file, sent to CALIFORNIA AND WESTERN MEDICINE for publication, and to the families of the deceased members.

The following are the standing committees of the Society, the last named in each being the newly appointed member:

Admissions—H. W. Lange, William Moore, and J. M. Krevitt.

Professional Conduct—Seymour Strongin, Keith S. McKee, and F. J. Gundry.

Grievances—C. I. Mead, J. M. Nicholson, and H. R. McAllister.

Program—J. M. Nicholson, L. H. Fox, and Keith S. McKee.

Publications—L. A. Packard, P. N. Root, and E. F. Colby.

Hospitals and Dispensaries—H. R. McAllister, C. I. Mead, and C. S. Compton.

Historians and Obituaries—A. R. Moodie, M. Schlothaurer, and L. B. May.

The scientific program consisted of a paper by Dr. Roderick A. Ogden on *Urinary Antiseptics.*

The meeting was adjourned, following which refreshments were served. C. S. COMPTON, *Secretary.*

PLACER COUNTY

The Placer County Medical Society met at the Freeman Hotel, Auburn, February 5.

The meeting was called to order by Dr. C. E. Lewis, President. In addition to Doctor Lewis, there were present the following members and visitors: Doctors Russell,

* Referred to Committee on Resolutions and approved at the State convention on the last day, at Long Beach, September, 1937.

Hirsch, L. B. Barnes, Paul D. Barnes, Atkinson, Lundegaard, Peers, Eveleth, Miller, Briner, Banks, Dunievitz, Vinks, Kindopp, and Hummelt. Visitors—Dr. Howard Morrow of San Francisco, President of the California Medical Association; Dr. C. E. Schoff of Sacramento, former councilor for the Eighth District; Doctors Fritz Tobias of Grass Valley, J. A. Trolan and Edwin S. Peeke, of Weimar, and Mr. Steve Dettman of Weimar.

The application of Dr. Edwin Slater Peeke for membership was read for the second time, and Doctor Peeke was unanimously elected.

Following the reading of correspondence, President Lewis introduced Dr. Howard Morrow, who gave an *Outline of the Plan for the Control of Syphilis by the State Department of Public Health.* He spoke about the Sacramento Clinic and the plan of treating pay and part-pay patients. He also gave an outline of the treatment which the Department of Public Health is advocating and showed some slides showing advanced and incipient types of syphilis and explained the different types of treatment which have been advocated. Doctor Morrow stated that continuous form of treatment is much superior to intermittent or irregular therapy.

The meeting concluded by round-table discussion, with Doctor Morrow answering questions. The discussion was general.

The meeting adjourned for refreshments.

ROBERT A. PEERS, *Secretary.*

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SAN BERNARDINO COUNTY

The regular meeting of the San Bernardino County Medical Society was called to order by the President on Tuesday, February 1, at 8 p. m., at the San Bernardino County Charity Hospital. About seventy members and guests were present.

Application for membership of Dr. Harry A. Tyerman of Needles was favorably voted on, as were the applications for transfer of Dr. E. Wilton Thomas of Colton, from Shasta County, and Dr. Joseph Langer of San Bernardino, from Siskiyou County.

The following program, a symposium on potent new therapeutic agents, was presented:

Benzedrin Sulphate—Fred B. Moor of Los Angeles and Lester H. Lonergan of Loma Linda.

Sulfanilamid—(*a*) General use, Joseph S. Hayhurst of Redlands; (*b*) Genito-urinary diseases, Ivan L. Finkelberg of San Bernardino.

Mandelic Acid—T. I. Zirkle of Loma Linda.

Fever Therapy—Walter Pritchard of San Bernardino.

Dr. W. W. Fenton, County Health Officer, outlined a plan for a venereal clinic.

Doctor Davy of the State Department of Public Health answered questions and a general discussion took place. In answer to the main question as to Social Service investigation of the patient admitted to the clinic, Doctor Davy did not know of a definite plan, although he felt sure that this would be adequate. He said that for first visits and diagnosis, patients would be taken care of regardless of their ability to pay, and that length of residence in the county would not play a part in a patient's eligibility to the clinic.

The meeting adjourned at 10:30 p. m.

ARTHUR E. VARDEN, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms at Stockton on February 3.

The meeting was called to order at 8:17 p. m. by Dr. A. C. Boehmer, President. The regular meeting was preceded by a supper meeting at the Hotel Wolf, at which twenty-three members and guests were present. The paper at the supper meeting was read by Dr. Dewey Powell, who reported on the recent meeting of the seventh annual Midwinter Clinical Group on Ear, Eyes, Nose and Throat, under the auspices of the Los Angeles Research Study Club.

The applications of Dr. Julius Shreiber and Dr. W. Charles Martin being favorably reported upon by the Admissions Committee, and there being no objections from the floor, were declared elected to membership. The petition of Dr. J. J. Seibel of Lodi was presented and referred to the Admissions Committee.

Correspondence requesting membership of the San Joaquin County Medical Society in the California Society for the Promotion of Medical Research was read, and on motion by Dr. Dewey Powell, seconded by Doctor Doughty, was referred to the Board of Directors for action.

Dr. C. A. Broaddus, reporting for the Postgraduate Study Group, stated that he had seen Doctor Thannhauser in Los Angeles recently, and Doctor Thannhauser commented several times very favorably on his recent trip to Stockton for the Postgraduate Study Group. Doctor Rohrbacher reported for Doctor Gallegos, chairman of the committee appointed by Dr. John Blinn in 1937 for a conference with a group reporting on the cancer clinic for the San Joaquin General Hospital in reference to the establishment of a similar group in Stockton for pay and part-pay patients. The committee had contacted St. Joseph's and Dameron's hospitals, and both institutions had agreed to furnish space and suitable equipment. The committee recommended that the San Joaquin County Medical Society look with favor upon the establishment of a cancer clinic. Upon motion of Doctor Doughty, seconded by Doctor Hull, the matter was referred to the Board of Directors for further study and development of a plan to be submitted at the next meeting of the Medical Societly.

Under miscellaneous business the Secretary read excerpts from a report of Doctor Gilman to the San Francisco County Medical Society in reference to malpractice insurance.

The papers of the evening were presented in the nature of a symposium by Dr. H. Brodie Stephens of San Francisco and Dr. Phillip J. Lipsett of Oakland. *Acute Intestinal Obstructions* and the symposium was profusely illustrated with lantern slides and x-ray plates. It dealt with diagnosis, pathology, and x-ray findings and treatment. The paper caused considerable discussion.

There being no further business to come before the Society the meeting was adjourned at 10:30 p. m. and refreshments were served.

G. H. ROHRBACHER, *Secretary.*

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SANTA CLARA COUNTY

The scientific program for the January meeting of the Santa Clara County Medical Society was arranged and presented by the resident staff of the Santa Clara County Hospital. The program, which followed dinner at which Dr. D. Wilson, hospital superintendent, was host, consisted of the following papers: *The Effectiveness of "Water-soluble" Iodin in Reversing the Wassermann Reaction* by Dr. Pierce Barrette, visiting neuropsychiatrist, based on work done in the out-patient department by the interne staff; *An Original Method of Suspending the Uterus,* representing a combination of the principles of the Curtis and Coffee techniques, devised and presented by Dr. Leon Fox and illustrated by a moving picture made at the hospital; *The Peregrinations of Several Swallowed Needles* by Dr. James Bullitt, visiting roentgenologist; *A Case of Multiple Fractures (Femur, Patella, Olecranon, Skull) with Unexpected Recovery* by Dr. K. M. McCoy, resident in orthopedics; *A Summary of Obstetrical Results for the Year and a Case of External Rupture of a Pyosalpinx with Tubo-Abdominal Fistula* by Dr. J. C. Jacobson, resident in obstetrics and gynecology; *Results of the Serum Treatment of Pneumonia* by Dr. E. P. Hockenbeamer, resident in medicine; *Report of the Isolation Service* by Dr. M. B. Morehead, resident in contagious diseases; *Internal Pneumolysis in the Treatment of Pulmonary Tuberculosis* by Dr. C. G. Scarborough, resident in tuberculosis; *An Evaluation of the Results of the Newer Methods of Thoracoplasty* by Dr. Doxey Wilson, hospital superintendent.

LESLIE B. MAGOON, *Secretary.*

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STANISLAUS COUNTY

The regular monthly meeting of the Stanislaus County Medical Society was held at the Hotel Covell on Tuesday, February 8. Dr. Joseph Azevedo presided.

The Secretary read a communication from the State Secretary which defined the disciplinary action to be taken in the event a member accepted a reduced fee from the industrial accident insurance companies.

On written request of the City Superintendent of Schools, Mr. Bradley, Doctor Azevedo, as President of the Society, asked that he be a member of a county coördinated health council. There were no objections.

Doctor Allen stated that insurance of malpractice type can be obtained through local insurance agencies.

Dr. Harris Wilson informed the Society that he had resigned as physician for the Eagle's Lodge, in accord with a former accepted proposal.

Dr. Ernest C. Dickson, professor of public health at Stanford Medical School, gave a very interesting and instructive talk on *Valley Fever,* illustrated by lantern slides.

The meeting ended after showing motion pictures on *Sterility.* HOYT R. GANT, *Secretary.*

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TULARE COUNTY

The Tulare County Medical Society held its first meeting for 1938 on Sunday, January 16, at Motley's Café. A dinner preceded the meeting. Dr. R. C. Hill presided.

There were present Doctors Clarke Smith, Ruth Wells, A. Bond, Lipson, Zumwalt, A. Miller, Weiss, Powell, Hill, Sorsky, Ambrose, Guido, P. Miller, Cronemiller, Matthias, Falk, Burton, Ginsburg, Furness, Seiberth, and Fillmore.

Following the dinner, Doctor Hill introduced the guest speaker, Dr. Eliot Sorsky of Fresno. Doctor Sorsky presented a paper on *Cardiac Pain,* including in his discussion a review of angina pectoris and coronary occlusion and differentiating chest pain of noncardiac origin. The talk was unusually clear and concise and provoked general commendation. A round-table of discussion followed.

The following members were unanimously elected for the year 1938: E. R. Zumwalt of Tulare, president; Phil Barber of Porterville, vice-president; K. F. Weiss of Visalia, secretary-treasurer. Censors—R. E. Cronemiller (1941), Ray Rosson (1940), A. W. Preston (1939), S. S. Ginsburg (1938). Delegate, R. C. Hill of Exeter. Alternate, A. V. Miller of Porterville.

Dr. R. C. Hill turned the gavel over to the incoming president, Dr. E. R. Zumwalt.

New applications for membership were read from Dr. F. G. Powell of Visalia and Dr. Ruth Wells of Springville. A request for transfer of membership by Dr. Charles S. Ambrose was made.

Dr. P. D. Miller was appointed to confer with Dr. A. E. Anderson, District Councilor, relative to the holding of postgraduate conferences in this district.

Dr. R. E. Cronemiller was appointed program chairman for the year 1938.

Dr. Elmo Zumwalt brought up the matter of his resignation of Tulare County Health Officer, and the following resolution was drawn up after a general discussion of the matter.

WHEREAS, It has been called to the attention of the Tulare County Medical Society that the resignation of Dr. Elmo R. Zumwalt as Tulare County Health Officer is to be in the hands of the Board of Supervisors within the near future; and

WHEREAS, Dr. E. Zumwalt states that he has learned after five years of activity in the health of Tulare County that the ever-increasing demands in this field of activity have reached such a stage that it is no longer possible for the Health Department to operate efficiently in the manner that has been the custom in the past; and

WHEREAS, Vital statistics plainly show a very marked increase in communicable and epidemic diseases which should and ought to be controlled by efficient measures and laws; and

WHEREAS, It has been called to the attention of this Tulare County Medical Society that numerous other counties in the State of California are now operating efficiently and economically under a full-time Health Department plan; and

WHEREAS, Doctor Zumwalt has in his possession facts and figures which clearly indicate that establishment of the Health Department will not add materially to the tax burdens of this county; therefore be it

Resolved, That this Tulare County Medical Society go on record as being unanimously in favor of the establishment of a full-time Health Department in Tulare County; and be it further

Resolved, That a copy of this resolution be placed in the hands of the Tulare County Board of Supervisors, with the recommendation that the Honorable Board of Supervisors, give serious thought and consideration to the facts set forth in this resolution, to the end that without further delay the establishment of a full-time Health Department for Tulare County shall become a reality.

The meeting adjourned at 10:20 p. m.

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The February meeting of the Tulare County Medical Society was held on Sunday evening, February 13, at Motley's Café in Visalia.

Dr. E. R. Zumwalt presided, and extended cordial greetings to the Woman's Auxiliary, who were present. Mrs. J. C. McClure, President, responded for the women members.

The program chairman, Dr. R. E. Cronemiller, introduced the guest speaker, Dr. Glenn Myers of Los Angeles, head of the Compton Sanitarium, who spoke to us on the *Structure of the Personality.* The paper was well received and provoked considerable discussion.

Initiating our local talent program, Doctor Cronemiller presented Dr. William A. Winn as the first fifteen-minute speaker. Doctor Winn chose as his subject, *Childhood Tuberculosis,* and amplified his paper with typical and unusually excellent x-ray films.

Three new members were voted on and unanimously elected to membership: Dr. Charles S. Ambrose and Dr. F. G. Powell, both of Visalia; Dr. Ruth Wells, Springville.

KARL F. WEISS, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (69)

Alameda County

Frank K. Haight
Melvin G. Hart
John M. Murphy

Contra Costa County

Henry D. Buckmann
Clifford E. Dieterich
Edward H. Morken

Fresno County

J. F. Bolkovatz
Harry W. Pasley
A. C. Pattison
J. A. Thormann

Lassen-Plumas-Modoc County

Sanford W. Cartwright

Los Angeles County

Herbert J. Andrews
Henry Bodner
C. W. Farley
Josif Ginsburg
Samuel D. Hart
Thomas M. Hearn
Rikita Honda
Robert W. Lawson
Carl E. Lund
Delia Lynch
R. W. Mapes
Scott S. McCune
Roy T. McReynolds
H. R. Milligan
Louis A. Motchan
J. R. P. Nicoll
Harry L. Schenk
Hans Schiff
Maurice Z. Silton
Charles M. Stewart
Daniel F. Sullivan
Hyman I. Vener
Erich Wolff
Duncan E. Stewart

San Bernardino County

Kenneth Ellsworth Kellogg
Mildred Van Cleve

San Diego County

Miriam Pool Huff
Ralph Mullenix

San Francisco County

Harry M. Elder
Frank C. Gassman
W. Wallace Greene
Charles T. Hayden
John Eugene Holko
Lot Duncan Howard, Jr.
Roy H. Morris
John W. Null
William Schiff
Robert B. Taylor
Robert Lowell Wagner
Walter M. Weber
Sidney N. Zuckerman

San Joaquin County

W. Charles Martin

Santa Barbara County

Arthur D. Bissell
Albert H. Satterlee

Santa Clara County

Richard Bigotti — Kathleen Kilgariff
Richard D. Cutter — Edwin Schultz
Tokio Ishikawa — Alvin B. Williams

Sonoma County

Bayley B. Bachelder

Tulare County

John S. Glenn — Ruth Wells
Forrest G. Powell

Ventura County

George H. Arnold — J. Alexander Mahan
William N. Nelson — Charles A. Wylie

Transferred (7)

David C. Cleave, from San Francisco County to Marin County.

Rudolph Dresel, from San Francisco County to Santa Clara County.

Richard D. Evans, from Santa Barbara County to Los Angeles County.

Franklin H. Garrett, from San Bernardino County to Ventura County.

Paul M. Hunter, from Monterey County to Los Angeles County.

Leonard M. Taylor, from Orange County to San Bernardino County.

Frank W. Yocom, from Stanislaus County to San Luis Obispo County.

Resigned (6)

Hamilton H. Anderson, from San Francisco County.
Florence O. Austin, from San Diego County.
Robert B. Spalding, from San Francisco County.
Grace McK. Talbott, from San Francisco County.
Edward M. Talbott, from San Francisco County.
Teru Togasaki, from San Francisco County.

In Memoriam

Buchner, George Otto Henry. Died at Bakersfield, December 12, 1937, age 58. Graduate of Cooper Medical College, San Francisco, 1907. Licensed in California in 1908. Doctor Buchner was a member of the Kern County Medical Society, the California Medical Association, and the American Medical Association.

✝

Hagedorn, Edwin Francis. Died at Modesto, September 7, 1937, age 52. Graduate of Albany Medical College, New York, 1908. Licensed in California in 1921. Doctor Hagedorn was a member of the Stanislaus County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Hay, Emil O. Died at Los Angeles, October 15, 1937, age 74. Graduate of the University of Southern California School of Medicine, Los Angeles, 1902, and licensed in California the same year. Doctor Hay was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Houghton, Arthur D. Died at Los Angeles, January 23, 1938, age 67. Graduate of Hahnemann Medical College and Hospital, Chicago, 1902. Licensed in California in 1903. Doctor Houghton was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Kilbourne, Norman Joseph. Died at Los Angeles, January 16, 1938, age 48. Graduate of Rush Medical College, University of Chicago, 1924. Licensed in California in 1925. Doctor Kilbourne was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Lando, Milton Ellis. Died at Oakland, January 31, 1938, age 60. Graduate of Cooper Medical College, San Francisco, 1900, and licensed in California the same year. Doctor Lando was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Lopez, Ernest Antonio. Died at San Francisco, February 1, 1938 age 41. Graduate of Indiana University School of Medicine, Bloomington, Indiana, 1924. Licensed in California in 1929. Doctor Lopez was a member of the Alameda County Medical Association, the California Medical Association, and the American Medical Association.

✝

Montgomery, John Lawrence. Died at Los Angeles, January 24, 1938, age 48. Graduate of Bennett College of Eclectic Medicine and Surgery, Chicago, 1911, and licensed in California the same year. Doctor Montgomery was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Steele, John Taylor. Died at Dunsmuir, November 28, 1937, age 38. Graduate of the University of Manitoba, Faculty of Medicine, Winnipeg, 1924. Licensed in California in 1931. Doctor Steele was a member of the Siskiyou County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Wiese, Walter Fred. Died at Fresno, January 29, 1938, age 50. Graduate of the University of Illinois College of Medicine, Chicago, 1915. Licensed in California in 1917. Doctor Wiese was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Charlotte Johnson Baker
1855–1937

In the passing of Charlotte Johnson Baker last October, San Diego lost a well-beloved and highly respected citizen. A woman who appreciated the value of her citizenship and never failed to use her influence for civic betterment.

Doctor Baker was a native of Newburyport, Massachusetts, received her A.B. at Vassar College and her M.D. at Michigan University. She served as athletic director at Vassar, following which she was assistant to Dr. Eliza Mosher at the Women's Reformatory at Sherbourne, Massachusetts.

In 1888, she and her husband, Dr. Fred Baker, with two small children, came to San Diego and became identified with the life of the community. In addition to carrying on a large and successful practice, she delivered over one thousand babies without a maternal death. She was a prime mover in civic affairs, especially those associated with the welfare of women and children.

Doctor Baker stumped the county for woman suffrage and was given credit for a large share of the big vote. She was the first president of the W. C. T. U. and of the county organization; she helped to organize the Y. W. C. A., and was its second president; she was an organizer of the Children's Home and for a time did all its medical and surgical work; she was an organizer of the Women's Civic Center, the most influential women's group in the county; also of the Young Women's Vocational Home, a charity which was utilized by every social-work group in the county, including the Immigration Service.

Doctor Baker served as president of the San Diego County Medical Society, the first woman to hold such office in California. She also served one term as vice-president of the Southern California Medical Society.

In 1913 the Bakers started on a trip around the world, but their plans were cut short by the advent of the World War, and after some thrilling adventures they reached home, after twenty-three months of wandering. About this time Doctor Baker developed angina pectoris from which she suffered severely for twenty years.

In spite of this she served for eleven years on the City Civil Service Commission, being a large factor in making it one of the outstanding Civil Service Commissions in the country.

In late years she was elected honorary member of the County Medical Society, W. C. T. U., Y. W. C. A., Women's Civic Center, and the San Diego branch of the American Medical Women's Association.

For the last six years of her life, though closely confined to her home and bed, she never lost interest in public affairs and was fully abreast of the times up to the day of her death.

LILLIAN B. MAHAN.

✠

George Otto Henry Buchner
1880–1937

Dr. George O. H. Buchner passed away on December 12, 1937, thus bringing to an untimely end a very useful life.

Doctor Buchner was born in Siskiyou County, California, and attended Cooper Medical College, where he received his degree in 1908. He started his practice in Bakersfield in 1910. At one time he dropped his work to devote all his time to oil interests, but returned to his medical practice three years ago.

Doctor Buchner was a most capable surgeon and understanding physician. His passing has been a great loss to the community.

(Signed) A. R. MOODIE, M.D.
MADGE SCHLOTTHAUER, M.D.
LUCILLE B. MAY, M.D.
Committee.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS President
MRS. FRED ZUMWALT Chairman on Publicity

State News

Members of the Board of Directors of the Woman's Auxiliary to the California Medical Association convened at ten o'clock on Wednesday morning, February 23, at the Hotel Huntington, South Oak Knoll, Pasadena. At one o'clock, luncheon was served in their honor.

Immediately following the afternoon session of the Board, a tea, honoring the out-of-town members, is being arranged by Mrs. Eliot Alden, President of the Los Angeles Auxiliary. The place will be announced at the luncheon.

Mrs. Arthur T. Newcomb, Convention Chairman, is in charge of arrangements.

News Letter

Dear Auxiliary Members:—This has been a memorable year for the Auxiliary! Increased membership in all of the counties; greater activity along philanthropic lines; interest shown and action taken toward understanding of legislation affecting the medical profession; growing understanding between members of the groups—this last is strongly marked and most important.

We have three new county auxiliaries! News of the organization of Tulare County has just reached me; Mrs. J. C. McClure of Lindsay is the president. We are most happy to welcome this group and predict a prominent place for them in Auxiliary affairs, as their president has all of the qualifications necessary for leadership. Then, too, Tulare is a wide-awake and growing county.

Courier time again! Each member should have received, on or before the fifteenth of April, her copy of the Auxiliary publication. If you have not, kindly communicate with Mrs. Arno G. Folte, 2326 Fulton Street, San Francisco, who is Mailing Chairman. The staff of the *Courier* regrets the fact that it will not be possible to send additional copies to county presidents, as was done in November. *County Presidents, please note.* The *Courier* goes to press on the *twentieth day of March!* May I ask you to cooperate with the staff and send the information requested of you immediately, if you have not already done so. We are planning a paper with which we hope you will be pleased, and your aid is needed.

Very sincerely yours,
MRS. FRED H. ZUMWALT.

Component County Auxiliaries

Alameda County

At a meeting of unusual interest, members of the Woman's Auxiliary to the County Medical Association will come together at the Claremont Country Club on Friday, February 18, at 2:30 p. m.

Excellent music has been planned for the occasion, consisting of a string trio, with Helen Shutes, violinist, Margaret Avery Rowell, cellist, and Thelma Olin, pianist. They will play the Hayden trio in G Minor and two other numbers. Adelaide Carrothers, soprano, who is prominent in East Bay musical circles, will sing. Her accompanist will be Dorothy Wines Reed.

Presiding will be Mrs. A. A. Alexander, president of the organization. Mrs. C. A. Dukes will be hostess of the day. Mrs. Albert Boles, a member of the Board of Directors, is reservation chairman.

Mrs. Frank Law, who is prominent in civic affairs of the State, will speak on the subject, *California's Women Prisons.* As Mrs. Law is one of the best informed people in the State on this subject, a great deal of interest will be aroused by her presence.

MRS. GRANT ELLIS, *Chairman of Publicity.*

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Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met at twelve o'clock on Tuesday, January 25, in the auditorium of the Orthopedic Hospital. Our president, Mrs. Eliot Alden, presided.

A one-act play was presented by the Department of Educational Activity of that institution. The cast comprised only handicapped children.

Dr. Harold E. Crowe was the guest speaker, and talked on *Growing Pains.*

Honor guests at the luncheon were various leaders of the Parent-Teacher Association of Los Angeles city and county.

One of the largest and loveliest affairs ever given by the Auxiliary was the reception on February 10 in honor of our national president, Mrs. Augustus S. Keck. This was held at the home of Mrs. E. Eric Larson. More than five hundred invitations were issued.

MRS. ROBERT L. CARROLL, *Corresponding Secretary.*

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Marin County

The last dinner meeting of the Woman's Auxiliary to the Marin County Medical Society was held on Thursday, January 27, at the Marin Golf and Country Club. The most interesting part of our meeting was an informal talk by Mrs. M. E. Axline, assistant to the National Director of Volunteer Service of the American Red Cross. Mrs.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Axline spoke on the Braille transcribing service, and explained its history and methods.

It is reported that our benefit bridge tea, given at the home of our president, Mrs. Thomas Gocher, in January, had cleared enough to finance fifty subscriptions to *Hygeia*. These are to be placed in beauty shops, barber shops, schools, and dental offices throughout the county.

Mrs. Bernard J. Conroy, *Chairman of Publicity.*

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Monterey County

Our November meeting was held at the Forest Hill Hotel, Pacific Grove, at which time Dr. Garth Parker was the honored guest at our dinner. It was during Doctor Parker's term as county medical society president that our Auxiliary was founded.

Our Auxiliary was responsible for the Christmas decorations in the children's tubercular ward of the Monterey County Hospital in Salinas.

At the January meeting, held at the Hotel Del Monte, we had the pleasure of having the state president, Mrs. Hobart Rogers, and the state corresponding secretary, Mrs. Charles Hall, with us. Mrs. Rogers gave an interesting talk on the purposes and ideals of the Auxiliary.

A very successful card party was given on January 19 at the Women's Club House in Salinas. Mrs. Garth Parker was chairman of arrangements. The proceeds from this party are to be used for redecorating the children's tubercular ward at the county hospital.

In February the Auxiliary will meet at the Santa Lucia Inn at Salinas.

Mrs. A. A. Arehart, *Chairman of Publicity.*

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Orange County

Members of the Woman's Auxiliary to the Orange County Medical Association were guests of the latter at the fiftieth installation banquet of their society. This very enjoyable affair was held at the Santa Ana Country Club on January 11.

During dinner we were entertained by music played by the Orange County Ensemble. The master of ceremonies for the program of music and talks that followed the dinner was Dr. H. A. Johnson of Anaheim.

Dr. Carl Omeron, a dentist from Los Angeles, gave three vocal selections. He was accompanied at the piano by his wife. Mrs. G. Wendell Olson, President, brought "Greetings from the Auxiliary." The history of the Association, founded in 1889, was sketched by Dr. Waldo Wehrly of Santa Ana, the outgoing president. There is only one living charter member—Dr. James Boyd of Santa Ana. A toast to his health was proposed by Dr. Charles C. Violett of Garden Grove; he also spoke of Doctor Boyd's medical career. An address of appreciation to outgoing officers was presented by Dr. Willis Baker of Santa Ana, and one of welcome to incoming officers by Doctor Violett.

The dinner speaker was Dr. J. Whitcomb Brougher, Jr., Glendale pastor. He spoke of the necessity of good health.

Our next meeting will be postponed until February 21 to accommodate our state president, Mrs. Hobart Rogers, and Mrs. Charles Hall, the corresponding secretary, who will be our guests at that time.

Mrs. G. Wendell Olson, *President.*

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Riverside County

The Woman's Auxiliary to the Riverside County Medical Society reports several new members and a representative group of women at well-attended meetings. We are looking forward to our February meeting with pleasure. At that time we will have as guests our state president, Mrs. Hobart Rogers, and Mrs. Charles C. Hall, state corresponding secretary, both of Piedmont. They will be honored at a luncheon meeting, at which Mrs. Dexter Ball of Santa Ana will also be present.

Members of the Auxiliary are working long and earnestly to make a success of the Community Chest drive, which they are actively interested.

Mrs. T. A. Card, *President.*

Sacramento County

The annual dinner dance of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the Sutter Club on Saturday evening, February 5.

Some two hundred members and guests met in the ballroom of the Sutter Club at 8:30 o'clock to dine and dance.

Mrs. Augusta Keck of Altoona, Pennsylvania, President of the National Auxiliary, and Mrs. Hobart Rogers of Oakland, State President, were the guests of honor. Others seated at the head table were: Mrs. William Van Den Berg, President of the Sacramento Auxiliary; Dr. William Van Den Berg, Dr. Hobart Rogers, Dr. and Mrs. Dave Dozier, Dr. and Mrs. George Briggs, Dr. and Mrs. Frank MacDonald, Mr. and Mrs. Lawrence Ashley, and Mrs. J. B. Harris.

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The January meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held on January 18 in the home of Mrs. George A. Briggs, 1127 Forty-fifth Street.

A short business session was followed by bridge, music, and refreshments.

Assisting Mrs. Briggs as hostesses were: Mesdames C. L. Bittner, Dave F. Dozier, L. C. Barrette, Russell Harris, Wayne Pollock, John Lawson, and S. G. Christian.

Mrs. Hugh Carmichael, *Chairman of Publicity.*

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San Diego County

The Woman's Auxiliary to the San Diego County Medical Society held its annual dessert bridge benefit parties in the homes of five of their members in order to raise their quota for philanthropic purposes for the year.

The parties were held in the homes of Mrs. W. D. Rolph, Mrs. H. G. Holder, Mrs. E. F. Chamberlain, Mrs. Hervey King Graham, Mrs. W. W. Russell, Mrs. Willard H. Newman, and Mrs. T. S. Whitelock, Jr.

There were individual table prizes, cake raffles, and door prizes. The affair proved to be a very popular event, and was well received by all.

Mrs. Hobart Rogers, our state president, will be in San Diego on February 17, and a special meeting in the form of a tea at the home of Mrs. Willard Newman will be held. San Diego is indeed honored to have Mrs. Rogers as their guest at this time.

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San Francisco County

Honoring their national president, Mrs. Augustus S. Keck of Altoona, Pennsylvania, members and guests of the Woman's Auxiliary to the San Francisco County Medical Society assembled at a formal luncheon on Tuesday, February 8, at the Western Women's Club.

Mrs. Keck was making an official tour of the western states, and during her visit in the bay region was a house guest of Mrs. Hobart Rogers of Oakland, State President of the Woman's Auxiliary to the California Medical Association.

Mrs. Hans Barkan, as president of the San Francisco unit, presided over the luncheon, and had as honor guests, Mrs. Keck and the following state officers, councilors, and county presidents: Mesdames Hobart Rogers, Frederick N. Scatena, Harry O. Hund, Lawrence Knox, J. C. Geiger, Harold Trimble, George A. Briggs, Robert M. Furlong, A. A. Alexander, Thomas Gocher, W. J. Van Den Berg, F. G. Maggs, Henry Milo; Mrs Thomas J. Clark and Mrs. William H. Sargent, past state presidents. Also, Mrs. Howard Morrow, Mrs. William C. Voorsanger, Mrs. Andrew Henderson, and Mrs. Alfred Philips.

Mrs. George S. Becker was chairman for the luncheon, assisted by Mrs. Howard B. Dixon. Decorations were in charge of Mrs. John S. Humber, whose exquisite arrangements of spring blossoms and flowers enhanced the beauty of the spacious dining room.

Following the luncheon, Mrs. Keck delivered a brilliant address, outlining the high purposes of our organizations and the work possible for us to accomplish. Also, reference was made to the important part which the Woman's Auxiliary to the American Medical Association will per-

form next June when their national convention will be held in San Francisco.

Arrangements for the convention were made by Mrs. Keck during her visit here, and plans will proceed under the direction of Mrs. J. C. Geiger as general chairman, and Mrs. George S. Becker as chairman of entertainment.

A formal Valentine dinner will be given on Monday evening, February 14, at the Society's headquarters, for the members of the San Francisco County Medical Society and their wives. Mrs. William W. Newman is chairman, assisted by Mrs. Thomas E. Gibson, who will be in charge of the evening's entertainment. Dancing, cards, and music will be included. Hostesses will be Mrs. Hans Barkan, Mrs. Jerome W. Bettmann, Mrs. Fred D. Fellows, Mrs. Hans von Geldern.

Dr. William C. Voorsanger, President of the San Francisco County Medical Society, will honor the Auxiliary as guest speaker for Tuesday, March 15, 1:30 p. m., at 2180 Washington Street. Following the short business meeting, which will include the report of the Nominating Committee, an informal reception will be held to welcome the new members, numbering sixty to date.

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Typical San Francisco hospitality was manifested at the beautiful Valentine dinner party given by the Auxiliary for the members of the San Francisco County Medical Society and their wives on Monday evening, February 14, at the Society's headquarters.

Mrs. William W. Newman was chairman, assisted by Mrs. Thomas E. Gibson. Mrs. John D. Humber was chairman of decorations. Mrs. Hans Barkan, President, presided as hostess.

The spacious entrance hall was a bower of cloudy pink and white spring blossoms, interspersed with numerous candlelights, and a soft, glowing fire crackling in the huge old fireplace. In this setting, a large crowd gathered to exchange greetings and to enjoy the cocktail hour, during which the following songs were among those most graciously rendered by Mrs. Thomas E. Gibson, who was accompanied at the piano by Mrs. F. H. Redewill: The Habanera from Carmen, and the Zigeunerweisen Waltz—an arrangement of an old violin number set to music. Then Gianina Mia from the Firefly, and at the end that lovely old song, The Sweetest Story Ever Told.

Then the doors to the dining hall were thrown open, revealing another picture of charm and artistry in the arrangement of beautifully decorated tables with candlelight. The guests immediately entered, and a bountiful dinner was served, during which Mrs. Howard H. Markel favored the gathering with delightful songs, and also acted as leader for group singing. Dancing followed to a late hour, making the evening a grand success and a happy occasion long to be remembered.

Among the out-of-town guests were Dr. and Mrs. Hobart Rogers of Oakland, Dr. and Mrs. Harry O. Hund, and Dr. and Mrs. Robert M. Furlong of San Rafael.

Mrs. Harry R. Oliver, *Publicity Chairman.*

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Santa Barbara County

The Santa Barbara Auxiliary held no meeting during the month of December. In January the Auxiliary met for luncheon at the home of our president, Mrs. C. T. Roome. Fifteen members were present. At this meeting it was authorized that the sum of $10 be given to the most outstanding nurse in the graduating class of the Knapp College of Nursing.

Doctors specializing in diseases of the nose and throat will be in convention in Santa Barbara on January 28 and 29. Their wives will be entertained by members of the Auxiliary at this time. Mrs. Henry Profant, in charge of affairs, plans a garden tour and a no-host luncheon at the Coral Casino.

On January 28 there is to be a street sale of "infantile paralysis buttons." The Auxiliary plans to take a table.

The Medical Society gave the President's Birthday Ball at the La Cumbre Country Club. The Woman's Auxiliary proved most helpful. Mrs. Harold Schwalenberg and Mrs. C. T. Roome were members of the committee in charge of arrangements. Twenty-eight couples attended the affair, the first of its kind ever held here. It proved to be a distinct success; it is expected that it will be made an annual event, growing more popular each year.

Mrs. H. E. Henderson, *Chairman of Publicity.*

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Santa Clara County

On January 10, Mrs. William H. Milo of Mountain View, President of the Woman's Auxiliary to the Santa Clara County Medical Association, presided at a luncheon meeting of this group held at the Los Altos Country Club. Mrs. Lawrence Knox of Carmel, the district councilor, paid her official visit, and Mrs. Dana Thomas of San Jose spoke on her world travels. There were twenty-six members present.

At the regular monthly meeting, held at the St. Claire Hotel on February 7, Anna Law of the Board of Trustees of the California Institute for Women at Tehachapi was the speaker.

Mrs. R. W. Wright, *Corresponding Secretary.*

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Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met on January 10 at the Rio Del Mar Country Club. This was a luncheon meeting, at one o'clock, graciously presided over by our president, Mrs. Alfred Phillips.

Our guest of honor was our state president, Mrs. Hobart Rogers, who gave a very interesting and instructive talk on the *Unity of Purpose in the Auxiliary.*

Our Auxiliary is newly organized, but we are already able to forecast a most successful year.

Mrs. R. C. Alsberge, *Chairman of Publicity.*

New Treatment of Urticaria and Quincke's Edema.—Wolpe evaluates the customary treatments of urticaria and Quincke's edema, suggests that the two conditions might be related and directs attention to the difficulty in keeping all allergic substances away from sensitive patients as well as to the difficulties involved in specific desensitization. He made efforts to find a substance by which the cutis and subcutis (the system especially involved in urticaria and Quincke's edema) could be desensitized not only against the substance itself, but also against other urticariogenic substances. He reports the history of a woman, aged forty, who was subject to urticaria and who, after having been stung by a bee, developed a severe anaphylactoid urticaria which spread over the entire body. The urticaria responded to the intravenous administration of calcium. However, to free the woman from the predisposition to urticaria, the author tried desensitization with a bee venom preparation. Although it was feared that a new anaphylactoid urticarial attack might be elicited by the preparation, this was not the case and the desensitization was successful in that, although formerly the woman had had urticarial attacks every six weeks or eight weeks, during the five years following the desensitization, during which the patient remained under the author's control, she remained free from urticarial attacks in spite of the fact that her food was not restricted and that she was occasionally stung by bees or wasps. Encouraged by this success, the author tried desensitization with bee venom in twenty-five other patients with urticaria. Of these, fifteen remained entirely free from attacks thereafter, in six the attacks became less frequent and milder, and the four others could not be found for further control. After having used the bee venom desensitization for a year successfully in urticaria, the author decided to try it also in Quincke's edema. He describes the history of a man in whom the intravenous bee venom therapy not only cured the existing attack, but prevented relapses of the allergic disorder. In the subsequent four years the author treated successfully five other cases of Quincke's edema by means of bee venom therapy. He suggests that the capacity to effect an organ specific desensitization probably is not restricted to bee venom preparations, but that this effect might be elicitable also with other cutaneously active, urticariogenic substances.—*Wiener Klinische Wochenschrift.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

* * *

American College of Physicians, New York, April 4–8, 1938. Mr. E. R. Loveland, 4200 Pine Street, Philadelphia, Executive Secretary.

California State Dental Association, Stockton, April 4–6, 1938. C. E. Stabler, D.D.S., 1003 Medico-Dental Building, Stockton, General Chairman.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of March is as follows:

Thursday, March 3—KECA, 11:00 a. m., The Road to Health.

Saturday, March 5—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, March 10—KECA, 11:00 a. m., The Road to Health.

Saturday, March 12—KFI, 10:00 a.m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, March 17—KECA, 11:00 a. m., The Road to Health.

Saturday, March 19—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, March 24—KECA, 11:00 a. m., The Road to Health.

Saturday, March 26—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, March 31—KECA, 11:00 a. m., The Road to Health.

American Board of Obstetrics and Gynecology: Examinations.—The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Application for admission to the June, 1938, Group A examinations must be on an official application form and filed in the secretary's office before April 1.

The annual informal dinner and general meeting of the Board will be held at the Palace Hotel on Wednesday evening, June 15, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association will be the guest speaker, and the diplomates certified at the preceding days' examinations will be introduced individually. All diplomates are invited to attend the dinner meeting and to bring as guests their wives and any persons interested in the work of the Board.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Reaction Time of Boys Faster Than That of Girls.—Boys are faster than girls in reaction time, but the difference grows less in later years of adolescence and tends to disappear with practice. This finding by Dr. Harold E. Jones, Director of the University of California Institute of Child Welfare, is among several he has published in an article written for *The American Journal of Psychology.*

In the article he describes an apparatus constructed at the Institute to measure the speed of reaction, measuring time intervals in small fractions of a second. It includes a synchronous motor chronoscope, which records the time that elapses between hearing or seeing a stimulus, and making a manual response to this stimulus.

In a study of several hundred children, Doctor Jones found marked differences between age groups. At four and a half years the average reaction time to a sound is about two-fifths of a second, dropping slightly with increasing age to an average of one-sixth of a second at twelve years. Beyond this age there is little difference. Within groups, however, individuals vary greatly, at fifteen the fastest respond in about an eighth of a second; the slowest require a quarter of a second.

The difference in time reaction of boys and girls, Doctor Jones says, is probably due in part to differences in interest and incentive. The evidence clearly indicates, however, that the age growth in this ability, up to about twelve years, is related to fundamental neuromotor changes in the developing child.

Tulare County Has First Tularemia Case.—It is a fact that the first case of tularemia was not found in Tulare County. Recently, that county has reported its first case of tularemia although the causative organism, B. tularense, is named for the county where it was first discovered. This unusual situation is explained by the fact that Doctors McCoy and Chapin of the United States Public Health Service, way back in 1910, were examining ground squirrels of Tulare County in a search for plague. In the course of their investigation they saw an organism which bore certain characteristics of B. pestis, but which was not that organism. They were unable to associate it with any specific pathogenic condition in human beings or in animals. So they named it B. tularense in honor of the California county where, through accident, it first became recognized as a distinct entity.

In 1911, Dr. Edward Francis, also of the United States Public Health Service, was detailed to Utah for the purpose of investigating cases of "deer-fly fever," so-called because of the fact that the deer fly was seemingly responsible for the transmission of the unusual disease in human beings. He found in these cases the same organism that Doctors McCoy and Chapin had discovered in California, and lesions produced in Utah rodents were identical with those in California ground squirrels. The term "deer-fly fever" was discarded and tularemia used in its stead.

Later investigations proved that the disease, primarily a disease of wild rabbits, is widespread throughout most of the United States and in many parts of the world. Furthermore, it was determined that the chief vector of the infection is the common wood tick. Credit for this interesting and important epidemiological study is due the United States Public Health Service in 1910-1911, and in later years.

California's public health workers are interested because of the fact that this disease, named after a California county, is now known throughout the civilized world. But, until now, it is not known that a case of tularemia in a human being has ever occurred in Tulare County, California.

Course on Diseases of the Digestive Tract.—The University of California Medical School announces a short postgraduate course in diseases of the digestive tract. This will be held on April 13 to 16, and will include such subjects as amebiasis, intestinal worms, diarrhea, constipation, intestinal obstruction, tumors of the colon, functional disorders of the stomach and colon, vitamins, rectal diseases, colitis, diverticulosis, the gastro-intestinal manifestations of neurosis, jaundice, appendicitis, diseases of the gallbladder, carcinoma of the stomach, digestive diseases in children, and peptic ulcer. Instruction will be given by lectures, demonstrations, and surgical clinics. The fee will be $20. Announcements, which will be ready about March 15, will be sent to alumni of the Medical School located in the western states. Others may obtain them by writing to Dean Langley Porter, University of California Medical School, Medical Center, San Francisco.

Socialized Medicine.*—How many doctors realize the dangers ahead of them? How many know of the influence working to upset the individuality of medicine? A great philosopher once said "Prejudices are like rats and men's minds are like traps." Prejudices get in easily, but it is doubtul whether they ever get out. This is especially true when socialized medicine is discussed, the social service worker, sociologist, and politician from their side and the doctor from his.

However, we must consider first of all the 130,000,000 lay persons, who must, after all, be the judges as to what will be best for them, and lay our prejudices aside for the common good. If we consider the amount of space and publicity given socialized medicine by the magazine and newspaper editors, one would naturally feel the immensity of the opposition strength. However, when we consider the actual workings and accomplishments of group or social medicine systems, it lets the air out of the balloon and seems much less formidable.

Strangely enough, neither the patients who are to be served or the doctors who do the serving are calling for this type of medicine. The sociologist and politician who make the most noise and derive the good do not want it for themselves or family, but claim they want it for those who cannot afford medical attention. The statistical structure upon which their premise is based is extremely unstable and will not bear close analysis.

All existing systems base payment upon services rendered by compulsory treatment of physicians and lead to three types of compulsion. First, the patient, whether well or sick, is compelled to pay for this service through insurance or taxes. Second, the doctor is compelled to give his service as prescribed by the "system." Third, the sick patient is compelled to accept services as rendered. *Is this the American way?*

Let us consider ourselves entering a hospital with symptoms of appendicitis. We are entered on Form PB614K with a diagnosis Number 412. We do not know the ability of the doctor assigned to us who is Number 113,420, and this becomes an overwhelming obsession. Do you believe that confidence in your doctor and his personal interest in you has curative value? This lack of confidence breeds fear and doubt, and worry engulfs and saps the strength which you need so badly. It may strangle your will power, and you begin to wonder why the doctor has not come in to see you since yesterday morning. You realize, of course, that your friends will be told you are "doing as well as can be expected." Yes, but what is expected? Your fever rises and your resistance falls. You become frantic. The Committee on Costs of Medical Care comforts you with the assurance that there is no cause for alarm. The doctor, Number 113,420, knows all about you. Did you not spend two hours filling out Form PB614K and MX16? They know you are patient Number Y1140 from Central District 14 and Subdistrict K, and you are assigned to doctor Number F71 for preliminary treatment in preparation for operation by surgeon D136. The records show you are doing nicely. The doctor does not have to come to see you because he can get all his information from a card index, Form 3D1492. This is efficiency, but bad medicine.

Socialized medicine is long on records and short on recovery. Do you wish to be classified or cured?

* A letter in *The Journal* of the Alumni Association of the College of Medical Evangelists, Los Angeles, by Paul D. Foster, M.D.

American Board of Ophthalmology: 1938 Examinations.—These will be held as follows:

San Francisco, June 13.

Washington, D. C., in October at time of meeting of the American Academy of Ophthalmology and Otolaryngology.

Also at time and place of meeting of Southern Medical Association, probably in December.

Application blanks should be obtained immediately from Dr. John Green, Secretary, 3720 Washington Boulevard, St. Louis, Missouri.

Another Human Rabies Death.—A part-time postman in Los Angeles County, engaged in the delivery of "special delivery" or registered letters, was bitten above the left ankle by a dog on October 21, 1937. Little was thought of the wound, although the pants leg was turn. Tincture of iodin was applied and nothing more was thought about the matter. (Only fuming nitric acid is of value in cauterizing the wound caused by the bite of an animal that may transmit rabies.)

On the second day of December, symptoms suggestive of rabies appeared in the postman and he was taken to a hospital, where he died on December 3. The onset was probably a few days before entrance to the hospital, as the patient complained of pain and numbness in the hands, arms, feet, and legs. In the hospital there was a stiffness of neck and back muscles, nausea, difficulty in swallowing, and convulsions.

Upon autopsy, portions of the patient's brain were removed and tissue used in animal inoculation, with results positive for rabies. Typical symptoms of rabies occurred in laboratory animals that were inoculated, and Negri bodies were demonstrated by direct smears.

This is the third human death from rabies to have occurred in Los Angeles County since June, 1937. More than two thousand rabid animals were discovered in California during 1937. Quarantines against dogs are in effect in at least two counties of California. Further efforts in the control of stray dogs throughout the State are essential in order to control this preventable but highly disastrous disease.

New Discovery in Vitamin B Complex Highly Potent.—The potent vitamin B, which already has gone a long way in the campaign to wipe out pellagra in humans and paralysis in chickens through the utilization of certain of its factors in crystalline form, has scored a new triumph. Scientists of the University of California have succeeded in crystallizing still another factor of the vitamin B complex, which, in this form, has quickly cleared up a pronounced dietary dermatitis in rats. Crude concentrates of this same factor have also been able to cure or prevent a certain type of anemia in both rats and dogs. This anemia, while not of the pernicious type, is just as destructive in its effects.

So recent is this discovery that the scientists have as yet had no opportunity to even approximate its potentialities. They merely describe it as a marked development in the field of nutrition. It has been given the name "Factor 1" until such time as a further exposition of its properties will allow a more definite identification.

Until now three other components of the vitamin B complex have been available in crystalline form. One of these, nicotinic acid amid, was crystallized at the University of Wisconsin, and has been found to be a potent specific in the treatment of human pellagra. Another member of the vitamin B complex, riboflavin, which has also been produced in crystalline form, has a marked effect in improving hatchability of eggs of poultry and also cures certain types of paralysis in growing chicks. Thiamin, or vitamin B, was the first member of the complex to be crystallized. There are one or more less well-known factors in this complex which have not yet been crystallized.

The factor crystallized by the University scientists here was obtained from a rice-bran preparation, but it is also known to exist in liver and in the outer coating and the germ of cereals. As yet there is no evidence that the new crystalline product will have any effect on the control or prevention of any ailments of man or poultry.

The discovery is announced by Dr. Samuel Lepkovsky, associate professor of poultry husbandry, who has done much notable work in this vitamin complex.

Medical School to Hold Reunion.—Medical men from all parts of the State are being invited to the semi-annual Alumni Day clinics of the University of California Medical School, to be held at the school on Tuesday, March 22. The program has been arranged by the William Watt Kerr Club, recently organized, and named after a late professor of medicine in the school.

"Moving Day" for Radiation Laboratory.—Beginning with the installation of its biological section during the week of February 7, the work of fitting up the new Radiation Laboratory at the University of California is progressing with all possible speed. The laboratory is to house the medical cyclotron, which will be given over to the production of a number of radioactive substances being used by University scientists in a new campaign against cancer, leukemia, and various other maladies.

While the medical cyclotron itself will be in place within the next month or so, it will be several months before it is in active operation. The task of wiring the great magnet is a tedious and an intricate one. Another major job is the one calling for the safeguarding of the laboratory staff through the installation of water tanks and other devices.

But four of the eight rooms in the new laboratory will be used at present, one of these being the control room. This will be completely separated from the cyclotron by a concrete wall and glass window.

At present the cyclotron is being operated on a sixteen-hour shift daily to turn out radiophosphorus for the University Medical School in San Francisco.

Syphilis and Blindness.—Syphilis has been responsible for an alarming amount of blindness and defective vision in the United States, says the National Society for the Prevention of Blindness in a statement urging widespread public observance of National Social Hygiene Day.

"There is a close relationship," the statement says, "between prevention of blindness and the campaign to stamp out syphilis, which is being so vigorously conducted by the American Social Hygiene Association and coöperating agencies. It is estimated that 15 per cent of all blindness is caused by syphilis.

"Hundreds of babies are either blind at birth or become blind later from prenatal syphilis. These tragedies are needless. It is an established fact that prospective mothers who have syphilis can bear healthy children if prenatal antisyphilitic treatment is administered in time. A blood test usually can determine the presence of syphilitic germs.

"If all cases of syphilitic expectant mothers are discovered and followed up with treatment, we may hope for a marked decrease in blindness and defective vision. This means also that a tremendous amount of human misery and economic waste will be avoided."

Alcoholics Were Ancient Problem.—Few problems which harass modern citizens are without counterpart in ancient history, declares Dr. Arthur Patch McKinlay, professor of Latin at the University of California, Los Angeles, whose academic hobby is matching modern situations with those of the ancient world.

"The recent decision of a New York judge in dismissing a charge of murder against a drunk driver opens up the age-old debate as to the responsibility of alcoholics," says Doctor McKinlay. "The ancient had to face the same problem. There were those who would hold drinkers to strict accountability. Among these was the Lesbian Pittacus, who provided in his laws that the penalty for drunk offenders should be twice as severe as for sober malefactors.

"On the other hand, the indulgent point of view had its supporters among ancient lawmakers. Among these was one Zaleucus, who formed a code of sumptuary laws for the Greek colonist's town of Locri in southern Italy. This lawmaker, according to Aristotle and other observers, recognized human frailty to the extent that though he limited a lady to one attendant, she might have two if she were drunk!"

Penrose Outlines Case of State Health Insurance at University of California.—The case of compulsory health insurance administered by the State, was presented at a lecture here by Dr. Ernest F. Penrose, associate professor of economics in the University of California. According to Doctor Penrose there are definite evidences that legislation will soon be presented placing every qualified person under this type of insurance, in order to properly equalize the costs of medical care, and to provide such care where it is not now being adequately given.

The asserted flaws in voluntary insurance were set forth at length by Doctor Penrose. The nature of the difficulties in the way of developing health insurance through commercial policies, was gone into by the speaker, and the strength and weakness of the fraternal type of insurance were also discussed. The speaker charged that voluntary insurance is often used to cover a variety of schemes in which a compulsory element is present.

Regarding illness as an insurable risk, Doctor Penrose states that it is more calculable than unemployment. "But the expenses of meeting actual losses will present more income difficulties in the case of illness than in the case of unemployment, until experience brings about a different result.

"Compulsory health insurance is a vital plank in modern reform platforms, but is not a complete remedy for existing deficiencies," the speaker said. "The main problems apparent are that of cost reduction through the organization of medical services in units of the most efficient size and the provision for more adequate medical care for persons without means.

"But the time is ripe for a big step forward," he declared. "The need for a comprehensive, statesmanlike handling of the problem by public interests and the medical profession is now apparent."

The lecture was one of a series on medical sociology arranged by the University of California Medical School.

Press Clippings.—Some news items from the lay press follow:

The Medical Indigent

In the present controversy between the California Medical Association and the management of the Los Angeles County General Hospital over the latter's conduct, the word "indigent" constantly recurs.

In such a matter, however, there are two kinds of indigents, and it is necessary to distinguish between them, particularly in the light of the Association's charge that the hospital is working indirectly toward a system of State medicine.

In the current issue of the New England Journal of Medicine, Dr. Michael Davis, Chairman of the Committee on Research in Medical Economics, points out the distinction between the legally indigent, who must be cared for at public expense both in sickness and in health, and the "medically indigent," who are fully self-supporting in health but whose financial margin is so slender that they cannot meet the expense immediately entailed in any serious sickness or accident. The first class automatically must depend on straight charity for treatment; what the latter can do for themselves depends on circumstances and disposition.

Given time, encouragement and a conscientious opposition to being objects of charity, many of the "medically indigent" can ultimately pay part or all of their bills for hospitalization, particularly if these are figured at cost. The General Hospital purports to do this and, where the beneficiary's condition warrants, it is part of its business to see that he pays what he can when he can.

Doctor Davis finds that local, state and national governments now spend about $500,000,000 in tax money for free medical care and that, if all states spent on the adequate scale of New York, this would be about doubled. Excluding the very rich and very poor, he estimates that the public at large pays about $2,000,000,000 to doctors, hospitals and related agencies. Of this, some two-thirds is in direct fees and the rest in taxes, insurance, and charitable contributions.

If correct, the figures indicate that the taxpayers have all they can do to provide adequate care for the legally indigent and to maintain essential public health services. But, generally speaking, the medically indigent are also out of the field of self-supporting private doctors and hospitals. Who is to look out for them?

Doctor Davis attempts no categorical answer. He suggests that it can be answered only from the results of a really comprehensive study of the whole subject, one in

which would participate not only doctors but experts in the fields of economics, sociology, and public costs.

It is a complex subject and one hardly to be diagnosed dogmatically on the basis of present information.—Editorial, Los Angeles *Times*, February 14, 1938.

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San Francisco City Employees' Health Insurance Starts Soon

Registration, Contracts, Begin About March 1

San Francisco's plan of health insurance for municipal employees, authorized by charter amendment a year ago, will be in operation within two weeks.

Shortly after March 1, membership certificates will be ready, and physicians and surgeons will be under contract to the Health Service Board.

Such was the general belief last night as the City Retirement Board approved the schedule of fees proposed by the Health Service Board. At the same time, it approved the type of contract to be entered into with physicians and surgeons.

$2.50 Per Month

The plan calls for a monthly assessment of $2.50 upon each city employee who becomes a member. All must be members except those exempted on religious grounds or because of prior health insurance commitments.

Members of city employees' families will be permitted to enter the plan at the same rates for adults, reduced rates for children.

The Board heard protests from members of the Library Staff Association, who pointed out that the compulsory $2.50 monthly dues will work a hardship upon those receiving $100 a month or less. Further consideration will be given to low salaried city employees, the Board announced.

Director Appointed

Approximately 140 physicians have already committed themselves to participate in the plan and numerous others are expected to enter into contracts. Through Dr. T. H. Kelly, the San Francisco County Medical Society expressed approval of the plan, with the understanding that revisions will be in order at the end of one year.

Dr. W. B. Coffey has been appointed medical director for the Health Service Board and will be recompensed at a rate based upon the total membership. Members will be permitted to choose their own physicians from those under contract. Physicians will be recompensed according to the approved schedule; hospitals will receive $7.20 a day for each member received.—San Francisco *Examiner*, February 16, 1938.

* * *

Transient Medical Test Banned

State Rules Against County in Social Disease Fight

There is no way to keep transients infected with social diseases out of California.

The Los Angeles County Supervisors learned that yesterday in a ruling by the State Board of Health, which said enforcement of the State law authorizing physical examinations at the State's borders could not be limited to migratory individuals.

Must Have Evidence

The State Board, taking notice of a resolution adopted by the Supervisors on January 25, said it recognized the menace of social diseases brought to the State by thousands of transients, but that the law requires evidence of disease and not mere suspicion of it before a visitor may be restrained.

The Supervisors' resolution asked that all transients be inspected at the State's borders. It was backed by a report from County Health Officer J. L. Pomeroy that 10 to 15 per cent of transients who come to Los Angeles are infected with social diseases.—Los Angeles *Examiner*, February 14, 1938.

* * *

Dog Tears Girl's Cheek Bone-Deep

Four-year-old Angela Santa Ana, suffering from the worst dog bite reported to the Health Department in several years, today was under treatment for possible rabies infection.

The child was bitten by the same small fox terrier that bit four other children yesterday. Her cheek was laid open bone-deep from eye to lip. The animal now is under observation in the humane shelter.

Others given the Pasteur treatment with Angela were Louis Hernandez, bitten on the hand, and Virginia and Josephine Martinez, each bitten on the finger. The fourth victim, Sam Martinez, was bitten on the lip, but has not been located for treatment.

The dog, it was said, was owned by the Martinez family, of 466 North Fremont Street.—Los Angeles *Evening News*, February 15, 1938.

Doctors and Lawyers to Tilt Over Court Rules

Santa Barbara, Feb. 13. — The Santa Barbara County Medical Society and the Santa Barbara County Bar Association will dine together at El Paseo tomorrow night and then enter verbal battle over rules of evidence as they now apply to the testimony of medical experts.

"Some Aspects of Medical Jurisprudence" is the tactful fashion in which the subject of the evening is announced. William I. Gilbert, Los Angeles authority on medical testimony in court, and Dr. Gilbert V. Hamilton, nationally known alienist of Santa Barbara, are the headline speakers.

Paul Sweetser, President of the Santa Barbara County Bar Association, will preside. Discussion is predicated on complaint of many physicians that their testimony is too chopped up by demands for "yes" or "no" answers to hypothetical questions to be of little real value to judge and jury.

Experts complain that they must refrain from being positive. Many judges and attorneys agree with them. There is another faction on the legal side, however, which maintains that too much latitude permitted experts in the witness box would give them undue power in swaying court and jury with theory and opinion.—Los Angeles *Times*, February 14, 1938.

* * *

Los Angeles Trailer Health Ordinance

Trailer camps are required to abide by strict health and sanitary regulations under an ordinance which today bore the approval of the City Council.

The measure provides that house trailers may be located on private premises only with the consent of the tenant of such private premises.

If occupants of house trailers desire to remain in the city more than ninety days in any twelve months, they must obtain permits from the City Health Department. The application fee is $5.—Los Angeles *Herald-Express*, February 10, 1938.

* * *

Chemical Treats Virus

Sulfur Compound Cures Distemper

New York, Feb. 10.—(AP)—Discovery of a sulfur compound, the first chemical in the history of medicine ever found effective in treating a virus disease, was announced today in science.

Flu and infantile paralysis are examples of human viruses. The new chemical cures distemper, an animal virus, and for the first time offers hopes for cures in the human field.

The announcement was made by A. R. Dochez, the man who found the virus of the common cold, and C. A. Slantez. The new drug is sodium sulfanilyl sulfanilate.

While chemicals have been found to treat most of man's germ diseases, no chemical has ever been effective against viruses.—Los Angeles *Examiner*, February 11, 1938.

* * *

"A Magnificent Job"

Exaggerated and inaccurate reports of epidemic conditions in the San Joaquin Valley among migratory workers have done a serious injustice to the State Department of Health and its workers.

Using part State and part Federal funds, the State health authorities operate hospitals on wheels in their drive against disease among the 25,000 families who are spending the winter in camps in California.

In view of misquotations attributed to the medical adviser of the Federal Farm Security Administration, it is a pleasure to quote the tribute of a spokesman for FSA to our State health authorities. Says he:

"The graver injustice is to the State Department of Health, for by inference, Doctor Williams is made to say that they are negligent and inefficient, and nothing could be more remote from accuracy.

"As a matter of fact, to my own knowledge, they are doing a magnificent job. We could actually have a situation here in California that would justify scareheads if it were not for the professional ability, devotion, and organizational skill in the use of their relatively small forces of such men as Dr. Dickie, Dr. Farnsworth, Dr. Uhl, Dr. Stadtmuller and others in executive positions, and their field staffs. And also the county health officers in the areas of chief congestion, the school nurses, the nursing service of the Council of Home Mission, and others of this intelligent and devoted brigade. No amount of praise or credit is too high for any or all of them."

We have criticized the attitude of some officials toward migratory workers and their families and we welcome all the more the opportunity to testify that the hearts of

Californians can be as warm as any.—San Francisco *News*, February 8, 1938.

* * *

"Socialized" Care of Sick

Washington, Jan. 29.—The long and often bitter controversy over establishment of a system of so-called "socialized" medicine in the United States approached a climax with publication of an inventory of the nation's health, prepared by the United States Public Health Service.

The survey was a thorough investigation by trained WPA workers of the health or disease condition of 2,800,000 persons in nineteen states. The findings promise to bring the problem of adequate medical attention for all people up for solution in the near future.

Preliminary parts of the survey report show that in a country which has many of the world's outstanding medical research organizations, the finest hospitals ever built and more than 110,000 practicing physicians, about half of the population is still not getting adequate medical care for either minor or major illnesses.

Needless Deaths

In general, the report said, the less money a person earns the greater are the chances that he and members of his family will die from diseases which could be controlled with proper medical treatment.

Approximately 55,000,000 of America's 130,000,000 population are members of families which have annual incomes of less than $1,000 per year, the survey disclosed, and "this group shows a higher rate of illness and a higher death rate, but receives less medical care for those illnesses or to prevent those deaths than the higher bracketed income groups."

In other words, public health service officials said, poor people cannot afford to get sick, yet they are sick more frequently and for longer periods than other groups primarily because of lack of money to pay for medical treatment.

Sickness Costs

The average yearly cost of treatment for a case of cancer is $342, for appendicitis $170, for diabetes $126, for pneumonia $98, for tuberculosis $61, and for heart disease $48, they said. "But if a member of one of these households develops cancer, pneumonia, diabetes, or appendicitis, the minimum cost necessary for adequate medical care can scarcely be made available from an income already crowded with expenses for food, clothing, and living quarters."

Health officials scattered through five different departments of the Federal Government said the health survey had brought the question of medical care of the poor to the point where a decision whether the Government should aid the indigent, and the physicians, themselves, must be made in the near future.—Los Angeles *Examiner*, January 30, 1938.

* * *

Larger Clinic Staff Urged

Additional doctors and nurses are required at the Health Department clinics to treat the increasing number of men and women with social diseases.

The Health Commission on Saturday forwarded a request for an increased personnel to the City Council.

Dr. George Parrish, City Health Officer, advised the Board that more than one hundred women patients were daily receiving treatment.—Los Angeles *Examiner*, January 30, 1938.

* * *

Every Sixth Person in California Getting Aid From Public

Sacramento, Jan. 31.—(INS)—Every sixth person in California is receiving some form of relief at public expense. In a survey completed today by International News Service it was revealed it costs more than $12,500,000 per month to care for approximately 306,883 individuals, either unemployed or physically unable to make their own livelihood. This does not include the thousands of persons cared for by welfare agencies such as the Community Chest, Salvation Army, Volunteers of America, various church charities or similar organizations.

It is costing California taxpayers more than $3,000,000 per month to care for some 260,000 persons by the State Relief Administration, a load 33 per cent higher than this date a year ago. In addition, the Federal Government contributes more than $4,000,000 monthly to about 333,000 persons on Works Progress Administration projects.

The State's aged aid assistance is growing by leaps and bounds, with the present load placed at 98,000 at a cost of nearly $3,500,000 per month and with more than 20,000 persons waiting for action on their applications.

Aid to some 25,000 dependent children costs another $453,000 a month, while the State's 5,233 sightless get $251,592.

Indigent aid furnished by counties runs $850,000 monthly and along with other relief assistance continues to increase.

How the relief load has grown during the past eight years is shown by figures which reveal that during the 1930-1931 fiscal year only 9,896 persons were receiving aged aid, which totaled $1,105,754.

The estimated load for the current fiscal year, ending June 30, is 108,427 persons. This will cost an estimated $7,916,579 monthly.

Blind assistance costs $264,486 for 1,528 sightless. This year 5,360 blind will get $697,400.

Needy children during 1930-1931, numbering only 15,607, received $1,610,708. This year's California's 31,584 dependent minors will get $1,912,134.

Unless there is a sharp reduction in State Relief Administration loads, the State may find itself running short of funds for this agency. At the present rate it is estimated it will cost $31,000,000 for the fiscal year ending June 30. There was only $48,000,000 budgeted for this purpose for the biennium ending June 30, 1938. This would leave a balance of only $17,000,000 for relief needs next year.—Los Angeles *Herald-Express*, January 31, 1938.

* * *

One Hundred and Six Thousand Killed by Accidents in 1937

Chicago, Feb. 1.—(INS.)—Death took no holiday in 1937.

One hundred and six thousand persons were killed in accidents in the United States.

Three hundred and seventy-five thousand others were permanently disabled.

Nine million four hundred thousand others were injured.

The estimated cost of this great jamboree of carelessness, based on partially completed figures announced today by the National Safety Council, was $3,000,700,000.

The grand total of accidents dwindled slightly from the toll in 1936. Experts credited this fact to a mild summer, which brought a decrease in heat deaths, rather than to greater caution among Americans. However, safety campaigns received some credit. The accident table was as follows:

	1937	1936	Per Cent of Chg.
All accidents	106,000	110,248	— 4
Traffic	39,700	38,089	+ 4
Home	32,000	37,500	—15
Occupational	19,000	18,000	+ 6
*Public	19,000	20,000	— 5

* Nontraffic.

The saving in life effected by moderate summer weather more than offset the increase of 1,600 in motor accident deaths and of 1,000 in occupational fatalities, the statistics show.

Major disasters played an unimportant rôle in the toll. The great majority of deaths occurred in one's and two's.

Falls were second only to autos, claiming 26,000 lives.

Burns killed 8,000, drownings 7,000, railroad accidents 4,000, not including crossing crashes; firearms 3,000, gas poison 2,000, other poisons 2,000, and miscellaneous causes 15,000.

The child accident total dropped sharply from 16,200 in 1936 to 15,000 in 1937.

Cut Auto Deaths

Twenty states cut auto deaths in the face of increased travel.

Milwaukee emerged as the nation's safest big city. It had only 10.8 deaths per 100,000 population in 1937.

Among cities under 500,000 population, Minneapolis was safest and Memphis next.

In larger cities, pedestrians were the largest single class of victims in all traffic accidents.

Steam railroad accidents brought 4,580 deaths during the first ten months of the year, although only twelve of the victims were passengers on trains. Most of the victims were trespassers. Many were employees. Some were motorists.

Forty airplane passengers were killed, the partial tabulations show.—Los Angeles *Herald-Express*, February 1, 1938.

* * *

Socialized Health Service Illegal

San Francisco Foundation, with No Choice of Doctor, Hit by Ruling

San Francisco, Feb. 18.—(AP)—A socialized medicine plan, under which families would pay a monthly fee to insure medical care in time of sickness or accident, was declared illegal here today by Attorney-General U. S. Webb.

Webb told Dr. Charles B. Pinkham, Secretary-Treasurer of the State Board of Medical Examiners, that circulars of the so-called "Health Foundation" indicated the plan violated the State Business and Professional Code, which prohibits the practice of medicine "under a fictitious name."

Webb said the members of the Foundation apparently had no choice of their physician, who would be selected and paid by the Foundation, and thus there was "no professional relation as between physician and patient."—Los Angeles *Examiner*, February 20, 1938.

* * *

Cure for Infant Disease Found

Bloomington (Ind.), Feb. 19.—(AP)—In seaweed and the peels of lemon, orange, and grapefruit, the University of Indiana School of Medicine has discovered a new remedy for cholera infantum.

The medicine is a mixture of agar-agar and pectin. The agar comes from Japanese seaweed; pectin from the peels.

The two promise the virtual finish of cholera infantum, once dread infant killer, curbed in recent years by better diets, but still taking lives in July, August, and September under the newer name, "diarrhea of infants."—Los Angeles *Times*, February 20, 1938.

* * *

Court Rules Wright Sane; Release Seen in Five Days*

Attorneys Clash with Judge; Airport Man Promises to Quit Liquor

Paul Wright, who was insane, according to a jury verdict, when he killed his wife and his "best friend," is sane now, but he cannot go free until five days have elapsed. Superior Judge Ben B. Lindsey, who yesterday declared that the evidence in favor of Wright's present sanity was "overwhelming," announced that under the law, Wright cannot be released for five days, during which time the question is still subject to reopening.

Subject to Demands

The District Attorney's office is entitled to demand that Wright submit the question of his present sanity to a jury—he chose to have the court decide—or any "interested party," including relatives of the victims, may make such a demand through the District Attorney.

However, the likelihood that any such action would be taken was so small that apparently all Wright has to do is to count the days until he goes free. . . .

The decision came at the end of a hearing that was marked by vociferous clashes between attorneys and the court, Wright's solemn promise to let liquor alone, a warning by Leavy that "if this man is released, I hope the court will never regret it," and Judge Lindsey's immediate and vigorous criticism of the deputy.

During it all, Wright sat, looking rested and refreshed but somewhat bewildered as the words clattered about his head. At the end of the hearing he filled out a questionnaire for the records and was returned to the psychopathic ward of the General Hospital.

Acquaintances Testify

The hearing began tamely enough with testimony by David P. Fleming, President of the Los Angeles Baseball Club; Police Chief E. H. Adams of Burbank; W. H. Thompson, airport ticket seller; Miss Pauline Roach, who was Wright's secretary; Oscar E. Wilkinson, jail attache, and Captain Clem Peoples, chief jailer.

They all said that they believed Wright was sane at present.

Then came the parade of the psychlatrists.

Phychiatrists Agree

Dr. M. J. Rowe, who testified at Wright's trial that he believed Wright was sane at the time of the shooting of Mrs. Evelyn Wright and John Kimmel, said that he had not changed his opinion.

"Evidently he was carrying out his own personal code when he acted as he did," said the doctor.

"If liquor had not entered into the picture, this thing might not have happened?" inquired Judge Lindsey.

"Probably not," said Doctor Rowe.

"He was sane then and he is sane now," testified Dr. Victor Parkin.

Declared Sane

Dr. Gustave Boehme, third of the alienists who testified at Wright's insanity trial in which the jury verdict saved him from the penalty of his manslaughter conviction, also declared that Wright was "sane all the time."

"I do not think that it is likely that he would repeat his act—if he stops drinking and remembers the lesson he has learned," said the witness.

Dr. Samuel Marcus, who testified for the defense at the original trial, clung stoutly yesterday to his theory of "hysterical dissociation" of personality, declaring that he still believed Wright was mentally unconscious at the time of the shooting.

"I never said he was insane," he testified. "He is sane now. The trial through which he has just gone is the greatest possible test of emotional stability."

Alcohol Blamed

Dr. M. G. Carter, also blaming alcohol for much of the trouble, said that Wright was sane, but advised "a certain amount of supervision by his relatives."

"Sane," said Dr. Charles L. Allen.

"Sane, but of an unstable disposition," said Dr. Edson H. Steele. "It would perhaps be a good idea to place him in a state hospital for a time, for observation."

"Sane. Probably would never do it again," said Dr. E. H. Williams.

Then Leavy arose.

"This is a very peculiar situation," he said. "I believe that it would not be unreasonable to keep this man under observation for a time.

"I hope, if he is released now, that the court will never regret it. The future responsibility will rest with this court."

Judge Objects

That brought, from Judge Lindsey, sharp-edged remarks.

"I am not dodging any responsibility, but I refuse to acknowledge that it rests on this court," he said.

"I haven't the nerve to send this man to a state hospital. In all my experience, this has been one of the few times when alienists were 100 per cent agreed on their findings.

"Mr. Leavy should have made his protests to the trial judge and should have asked for a jury trial on the issue now before us, if he wanted one. The burden should never have been placed on this court."

Attorney Jerry Giesler, who defended Wright, asserted:

"The duty of the prosecutor ended when the jury brought in its verdict declaring Wright insane at the time of the shooting."

Sobriety Pledge

Returning to Wright—temporarily the forgotten man as the wrangle proceeded—Judge Lindsey instructed him to stand.

He read him a lecture on good behavior, particularly with reference to liquor.

"I have your word and your promise that you will not drink any more?" he asked.—Los Angeles *Examiner*, February 22, 1938.

* * *

Paul Wright Quits Hospital Today*

"White Flame" Slayer of Wife, Best Friend Legally Free

Paul Wright, "White Flame" slayer of his wife, Evelyn, and his friend, John Kimmel, will return to society today, with the full citizenship privileges of any free man.

At 10 o'clock this morning he will walk from the psychopathic ward of the General Hospital legally free.

Wright was declared legally sane last Monday, after eight alienists stated he was no longer mentally unbalanced.

The same jury which found the former aviation executive guilty of manslaughter in his first trial later declared him insane at the time he shot and killed his wife and his friend last November 9.

Among those who will be on hand to greet Wright on his return to the big outdoors is Jerry Giesler, his attorney.

Giesler said last night that Wright intends to remain in Los Angeles, find a job and go to work to make a living and forget the unpleasant features of his experience.—Los Angeles *Examiner*, February 27, 1938.

* * *

Lost Doctor's Body Recovered

Country Physician Caught in Hailstorm

Cedarville (W. Va.), Feb. 21.—(AP)—Friends brought back from the woods today the briar-scratched body of a 72-year-old country doctor who lost his way answering a sick call in a storm and died of exposure.

Dr. James Henry Chapman saddled his horse Saturday night after receiving the call, and rode into the hills.

A heavy hailstorm struck this area after Doctor Chapman's departure. Searchers found that he had tied his horse, and tried to go ahead on foot. He fell over a cliff a few hundred feet away.—Los Angeles *Times*, February 22, 1938.

*See also editorial comment on "The Criminal Insane," on page 157.

LETTERS

Concerning first demonstration in California of x-rays by Founder-Editor Philip Mills Jones.

San Francisco, California,
January 29, 1938.

To the Editor:—The beautiful tribute to Dr. Philip Mills Jones in the January number of CALIFORNIA AND WESTERN MEDICINE brings to my mind the fact that he was, I believe, the first on the Pacific Coast to demonstrate the value of the then recent discovery of the x-ray by Professor Roentgen.

The San Francisco *Examiner,* Thursday morning, February 20, 1896, states:

That proper investigation and experiment might be made in this city, the *Examiner* sought and obtained the services of three professional men of this city to test the Roentgen discovery, furnishing them with all the apparatus obtainable in this part of the world. After three days of discouraging failure success came, a success so complete that the photographs made yesterday in this city during the *Examiner* experiments are as good, or better, than any others that have been described in the technical publications of the country.

The three specialists selected were: Dr. Philip Mills Jones, who had general charge of the experiments; Dr. H. P. Carlton and Mr. Allen H. Babcock. Doctor Carlton had devoted much time to amateur photography, and Mr. Babcock was a clever electrician.

In the *Occidental Medical Times,* Sacramento, May, 1896, page 309, there appears:

San Francisco Medical Society, Regular Meeting, March 10, 1896. The Roentgen or X-rays: Dr. Philip Mills Jones gave a demonstration of the Roentgen or X-rays.

I am writing this for your information,
1980 Washington Street.

Cordially,
W. R. P. CLARK, M.D.

Concerning California Publications in Pharmacology.

To the Editor:—We are glad to announce the inauguration of *The University of California Publications in Pharmacology,* under the editorial supervision of Doctors Gordon A. Alles, T. C. Daniels, Mayo H. Soley, and Chauncey D. Leake. These studies will appear irregularly in the series, but will be consecutively paged to form volumes of about 500 pages. The subscription price per volume will be $5. Bills, however, may be rendered annually on July 1 for the issues received to that date. The first of these papers should appear early in the spring of 1938, and it is expected that a volume will be completed about every two years.

The University of California Publications in Pharmacology will contain reports of original pharmacological studies from the University laboratories, together with occasional review and general articles relating to the science. The following titles, now in press, illustrate the scope of the series:

1. Prolegomenon to Current Pharmacology, by C. D. Leake.
2. Chemotherapy of Leprosy: Clinical Evaluation of Anti-Leprosy Drugs, by H. H. Anderson, G. A. Emerson, C. D. Leake, P. A. R. Cerqueira, E. Hurwitz and H. Moura-Costa
3. Local Anesthetic Activity of Certain Ethyl Ester Derivatives of 2-Furoic Acid, by N. M. Phatak.
4. Skin Absorption of Insulin with *Mucuna pruriens,* by B. E. Abreu and G. A. Emerson.
5. Narcotic Properties of Alkoxyethyl Carbamates, by G. A. Emerson and B. E. Abreu.
6. Notes on the Pharmacological Action of Dinitrophenylmorphin, by G. A. Emerson, S. J. Klyza, N. M. Phatak and C. D. Leake.
7. Metabolic and Respiratory Effects of Dinitrophenylmorphin, by B. E. Abreu, N. M. Phatak, G. A. Emerson, and C. D. Leake.
8. Blood Sugar Response of Habituated Rabbits to Increments in Dosage of Morphin, Dihydromorphinone and Dinitrophenylmorphin, by G. A. Emerson and N. M. Phatak.
9. Comparative Physiological Actions of Phenethylamin and of the Betahydroxyphenethylamins, by G. A. Alles and P. K. Knoefel.

These studies will be produced in paper covers and printed in the usual style of our monographs in series, page size 6⅛ by 9¼ inches.

We should be glad to send you on request a sample copy of No. 1 without charge.

Berkeley, California.

(Signed): UNIVERSITY OF CALIFORNIA PRESS.

Concerning annual membership statistics of Los Angeles County Medical Association.

(COPY)

LOS ANGELES COUNTY MEDICAL ASSOCIATION
ORGANIZED JANUARY 31, 1850
INCORPORATED JUNE 24, 1878
REINCORPORATED MARCH 29, 1926

To the Editor:—Referring to suggestions given in your letter of January 10, we wish to report that we have completed the table of membership totals, and enclose two copies for your files. We have been unable to ascertain the membership for the year 1902.

Very truly yours,
S. K. COCHEMS,
Executive Secretary.

Total number of members at the end of each year:

Year	No. of Members	Year	No. of Members
1901	16	1920	997
1902	?	1921	1098
1903	203	1922	1211
1904	278	1923	1241
1905	315	1924	1369
1906	359	1925	1450
1907	393	1926	1486
1908	398	1927	1537
1909	402	1928	1620
1910	457	1929	1759
1911	561	1930	1776
1912	600	1931	1879
1913	622	1932	1889
1914	668	1933	1781
1915	707	1934	1838
1916	729	1935	1992
1917	781	1936	2200
1918	819	1937	2357
1919	856		

Concerning the East Bay Hospital Conference: Oakland Area.

To the Editor:—Ellard L. Slack, Superintendent of Merritt Hospital, will head the East Bay Hospital Conference as president for 1938 as the result of the annual election of officers held by the representatives of twelve hospitals in the metropolitan Oakland area.

Dr. Benjamin W. Black, Medical Director of Alameda County, was named as vice-president and Alfred E. Maffly, Superintendent of Berkeley General Hospital, as secretary-treasurer. The East Bay Hospital Conference, official organization of the hospitals in this area, had as its outstanding achievement in 1937 the organization of the Insurance Association of Approved Hospitals, providing a mutual nonprofit insurance plan and giving complete hospital care to all members paying a premium of 90 cents per month.

President Slack reports 10,000 members have already been enrolled in this attempt to reduce cost of hospital care so that it will not become a burden on those in lower income brackets. Membership in the East Bay Hospital Conference, he adds, is composed of all hospitals maintaining high standards approved by the American College of Surgeons which have been officially endorsed by the national governing body.

The exchange of bad-debt information has been another new achievement of the Conference during the past year. Nine copies are made of every account turned over by any hospital member of the Conference for collection. These copies are of nine different colors and one copy is dis-

tributed by the secretary to each participating private hospital. Each hospital thus builds up its own bad-debt file and has in alphabetical order the bad-debt accounts of all the other hospitals in the community. The system has already proved its worth by revealing several patients who have had bad-debt records in several hospitals, where the second hospital has innocently extended credit to the patient who was already on another hospital's bad-debt list. Should such a patient again apply to a second hospital for credit, his past bad-debt record will already have preceded him and will be on file at the hospital. The second hospital will thus be in a position of refusing the bad credit risk or demanding adequate credit protection, and even demanding that the original hospital bill be paid to the other hospital before further credit is extended. This coöperative system promises to save the hospital members of the East Bay Hospital Conference many thousands of dollars of unpaid hospital accounts.

Following are the hospitals included in the Conference: Alameda County Hospital, Alameda Sanatorium, Alta Bates Hospital, Berkeley General Hospital, Children's Hospital, Cowell Memorial Hospital, East Oakland Hospital, Fairmount Hospital, Merritt Hospital, Peralta Hospital, Providence Hospital, and Richmond Cottage Hospital.

Respectfully submitted,

ALFRED E. MAFFLY,
Secretary-Treasurer.

Concerning Clinical Laboratory Law of California: Chapter 804, Statutes 1937.

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

San Francisco, California,
January 26, 1938.

To the Editor:—We thought you might be interested in the enclosed copy of Opinion No. NS-812, rendered on January 13, 1938, to the Board of Chiropractic Examiners by Attorney-General U. S. Webb, Lionel Browne, Deputy, and leave to your discretion whether same should be published in CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,

C. B. PINKHAM, M.D.,
Secretary-Treasurer.

(Editor's Note: The above opinion appears in the Special Article section in this issue, on page 230.

Concerning Dr. A. W. Meyer's Article.*

Stanford University, California.
January 24, 1938.

To the Editor:—I heartily appreciated receiving a complimentary copy of CALIFORNIA AND WESTERN MEDICINE for January, and I am greatly indebted to you for your generous and comprehending comment on my article. Since a companion article dealing with conditions in the shoulder, which appeared in the *Archives of Surgery*, actually did attract attention both at home and abroad, you should feel especially complimented on your words. Time may show that I am mistaken in some of my interpretations, but none of us here have been able to think of any other explanation than that offered, and in any case the destructions are such that medical men can no longer ignore them.

Stanford University,
Department of Anatomy.

With warmest regards,

Very gratefully yours,

A. W. MEYER.

Concerning rabies quarantine in Los Angeles County.

February 9, 1938.

To Members of the State Board of Public Health:

Report of action of Los Angeles County Board of Supervisors in re request to outline extent of area to be included in rabies quarantine:

Doctor Pomeroy was called before the Board of Supervisors on February 8. Supervisor Legg led the opposition on all details, stating that dog lovers would be flooding the Supervisors' chambers. Supervisor Lee Ford said if there could be exceptions in Santa Monica and Malibu districts, he would be in favor of the quarantine.

Mr. Roland McNitt, attorney representing dog owners of Altadena and Pasadena, spoke in favor, and recommended that the Supervisors approve Doctor Pomeroy's suggestions sent the State Department of Public Health.

Supervisor McDonough was in favor, and said that it meant if the Los Angeles County Board of Supervisors approve Doctor Pomeroy's request, that the quarantine established by the State could be modified from time to time as conditions warranted.

Supervisor Jessup moved that the Supervisors direct a letter to the Director of the State Department of Public Health giving their approval to Doctor Pomeroy's request.

Mrs. Rosamond Mae Wright, representing the dog owners, said she was in favor of this, but that in former days some of the officials in charge of quarantine misdirected their activities. She said the place for dogs is in yards, in homes, or on leash.

Doctor Pomeroy reported on spot quarantines, and stated that the city of West Covina was drawing up stringent regulations with reference to rabies, and also that the State quarantine was in effect at Long Beach. (Long Beach not under quarantine.)

Doctor Pomeroy agreed to every exemption which was requested in the matter of territory.

It was agreed that a letter be addressed to the State Board of Public Health approving Doctor Pomeroy's request, and that the Supervisors outline the area they desired placed under quarantine. This letter is supposed to be mailed Wednesday or Thursday of this week. On receipt of same, copy of the proposed quarantine will be forwarded to the members of the Board, with the request that they approve or disapprove.*

Very truly yours,

WALTER M. DICKIE, M.D.,
Director of Public Health.

Concerning a Spanish edition of the United States Pharmacopoeia.

COMMITTEE ON REVISION
OF THE
PHARMACOPOEIA OF THE UNITED STATES OF AMERICA
1930-1940

Philadelphia, Pennsylvania,
February 4, 1938.

To the Editor:—I enclose an announcement of the publication of the United States Pharmacopoeia, Eleventh Revision, in the Spanish language. This has just been released, and I would appreciate your making this announcement in the current number of your journal.

This service which the Pharmacopoeia has rendered in those divisions of the United States where the Spanish language is spoken and in Cuba, is also being appreciated in other Pan-American countries. It is a friendly gesture, and through many years has assisted in establishing a contact with the republics of Central and South American countries, which is very important in our Pan-American relations.

E. FULLERTON COOK,
Chairman, United States Pharmacopoeia Committee on Revision.

* * *

A NEW SPANISH EDITION OF THE UNITED STATES PHARMACOPOEIA

The Spanish Edition of the United States Pharmacopoeia, Eleventh Decennial Revision (U. S. P. XI), sponsored by the Board of Trustees of the United States Pharmacopoeial Convention, has just come from the press.

This edition was translated under the auspices of the Pan-American Sanitary Bureau in Washington. It forms a volume of 695 pages, with a detailed index, and at the end there is a list of official titles in both English and Spanish. Auxiliary Committees of Cuba, the Philippines, and Puerto Rico took part in the work of translation.

This is the fourth edition of the United States Pharmacopoeia which has been translated into Spanish and published

* Refers to article, "Use Destruction in the Human Body," in CALIFORNIA AND WESTERN MEDICINE, December issue.

* By vote of the State Board, the quarantine was approved.

by the United States Pharmacopoeia Board of Trustees. It was originally provided for use in the Philippines and Puerto Rico and also in Cuba, where it was promptly adopted as the official Pharmacopoeia. It is now also official in Costa Rica, Nicaragua (together with the French Codex), Panama, and the Dominican Republic.

The Board of Trustees, in announcing this new edition to the health departments of the republics of Central and South America have expressed the hope that it may be useful to them in the preparation of their own pharmacopoeias, and that it may assist in bringing about uniformity in titles, strengths, and standards of purity among the medicines used in Pan-American countries.

As it has required considerable time for the translation and printing of the Spanish Edition, alterations and corrections, published in the U. S. P., XI, First Supplement, which became official December 1, 1937, have been incorporated.

The book is now on sale by the distributors, The Business Publishers International Corporation, 330 West Forty-second Street, New York, N. Y.

Concerning the conquest of syphilis and gonorrhea. A statement from Surgeon-General Thomas Parran.

To the Editor: The conquest of syphilis and gonorrhea is not a task for official health agencies alone, nor yet for physicians alone. It still is a task for the whole people.

The American Social Hygiene Association is the one national voluntary agency primarily concerned with the prevention and cure of the venereal diseases. It is an organization through which citizens everywhere have an opportunity to do their part in this task.

The Association has been and continues to be not merely a valuable, but an indispensable ally of health authorities and the medical profession in their battles against these diseases. As a member of the Board of Directors of the Association and as a public official, I long have been in a position to observe how important to official health activities is the work of this voluntary agency and its affiliated state and local groups.

The Association's work is particularly needed just now to sustain the new national interest in the dangers of syphilis and gonorrhea, to explain approved measures of control and encourage their practical application, and to aid in the correction of social and educational conditions which favor the spread of these diseases.

By the union of public and private efforts we can minimize syphilis and gonorrhea and the ill health, suffering and waste they cause.

THOMAS PARRAN.

Concerning "the Foundation Prize" of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons.

Huntington, West Virginia,
January 11, 1938.

To the Editor:—Since the announcement a few weeks ago of the award to be made by this Association there have been many inquiries received by the secretary.

I am enclosing to you a copy of the rules governing the awarding of this prize. I will appreciate it very much if you will run this in your journal as a news note. There may be members of the profession in your State who would be desirous of submitting a manuscript in this competition.

With my very kind regards, I am

Sincerely yours,

JAMES R. BLOSS, M.D.,
Secretary.

* * *

Rules governing the award of "The Foundation Prize" of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons:

1. The award, which shall be known as "The Foundation Prize," shall consist of $500.

2. Eligible contestants shall include only (*a*) interns, residents, or graduate students in obstetrics, gynecology, or abdominal surgery, and (*b*) physicians (with an M.D. degree) who are actively practicing or teaching obstetrics, gynecology, or abdominal surgery.

3. Manuscripts must be presented under a nom de plume, which shall in no way indicate the author's identity, to the secretary of the Association together with a sealed envelope bearing the nom de plume and containing a card showing the name and address of the contestant.

4. Manuscripts must be limited to 5,000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis.

5. The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the journal of the author's choice. Unsuccessful contributions will be returned promptly to their authors.

6. All manuscripts entered in a given year must be in the hands of the secretary before June 1.

7. The award will be made at the annual meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation.

8. The president of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the secretary of his name and address at least two weeks before the annual meeting.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

The Legal Status of Physicians Under the Workmen's Compensation Act

Summary of Industrial Accident Legislation.—In 1918 the people of California adopted a constitutional amendment which created an Industrial Accident Commission and vested in the legislature plenary power to create and enforce a complete system of workmen's compensation. The constitutional amendment defines such a system as including "full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury." (Article XX, Section 21, Cal. Const.)

The Workmen's Compensation Act, adopted by the legislature pursuant to the constitutional provision, uses the following language with respect to medical and hospital treatment: "Where liability for compensation under this Act exists, such compensation shall be furnished or paid by the employer and be as provided in the following schedule: (*a*) Such medical, surgical, and hospital treatment, including nursing, medicine, medical and surgical supplies . . . as may reasonably be required to cure and relieve from the effects of the injury, *the same to be provided by the employer,* and in case of his neglect or refusal seasonably to do so, the employer to be liable for the reasonable expense incurred by or on behalf of the employee in providing the same; provided, that if the employee so requests the employer shall tender him one change of physician and shall nominate at least three additional practicing physicians competent to treat the particular case, or as many as may be available if three cannot reasonably be named, from whom the employee may choose; the employee shall also be entitled, in any serious case, upon request, to the services of a consulting physician to be provided by the employer; *all of said treatment to be at the expense of the employer.*" (Deering's General Laws, Act 4749, Section 9a.)

Section 16 of the Workmen's Compensation Act provides for medical examinations of employees upon written request of the employer, which examinations are to be made by a practicing physician and are to be paid for by the employer.

Thus it may be seen that, under the Workmen's Compensation Act, medical, surgical and hospital treatment must be made available to injured employees, and the services must be rendered by physicians *selected and paid for by the employer.* The Act authorizes employers to protect themselves against liability for compensation (which includes cash award and medical and surgical treatment

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

and hospital facilities) by taking out insurance in a private company authorized to write workmen's compensation insurance, or in the State Compensation Insurance Fund, an insurer operated by the State of California. Inasmuch as most all employers avail themselves of the right to secure insurance, it follows that in most instances payment for physician's services to injured employees is made by an insurance company for and on behalf of the employer under an insurance contract by which the insurance company agrees to assume the employer's liability under the Workmen's Compensation Act in return for stated premiums. Hence, although the Workmen's Compensation Act imposes the liability for payment of physician's services upon employers, as a matter of actual practice such payment is made by the insurance carriers for the employers.

Effect of Workmen's Compensation Constitutional Provisions and Statutes on Practice of Medicine—Corporate Practice.—At this point it should be made clear that the Workmen's Compensation Act is a statutory exception to the general rule that a corporation may not engage in the practice of medicine or surgery. The people of California, through their Constitution and the Workmen's Compensation Act, have determined that for the purpose of industrial injuries only, it is competent for a corporation, *i. e.,* an employer and its insurance carrier, or both, to select physicians for third persons, *i. e.,* injured employees, and to pay for the professional services of the physicians so selected. This is the practice of medicine or surgery by corporations, since corporations control the payment for professional services rendered to others, but it is not in this instance unlawful because of express constitutional and statutory provisions. It is, of course, in all *other* instances unlawful.

Right of Physicians to Compensation Where Employee Treated Was Hired in Another State.—If a physician renders professional services to an injured employee, and the employee does not seek an award of compensation from the Industrial Accident Commission, the physician cannot commence a proceeding before the Commission for compensation for medical services unless the injured employee is also a party to the proceeding. (*Pacific Employers Ins. Co.* vs. *French,* 212 Cal. 139; *Independence Ind. Co.* vs. *Industrial Acc. Comm.* 2 Cal. (2nd) 397.)

The most difficult problems with regard to the Workmen's Compensation Act arise from the fact that present-day commercial and business enterprises are nation-wide and even world-wide, so that employees are often employed in one state and work in another state. When an employee is employed, say, in State A to work in State B, and is injured while in State B, a question at once arises as to which state, A or B, has jurisdiction under its Workmen's Compensation Law. This problem is extremely important to physicians, and may be illustrated by reviewing the case of *Pacific Employers' Ins. Co.* vs. *Industrial Acc. Commission,* 95 Cal. Dec. 107, decided by the Supreme Court of California on January 31, 1938. The facts were these: One Tator, a chemical engineer, was employed in Massachusetts by a business concern, and several years later was sent to a branch plant of his employer located in Oakland, California, for the purpose of solving, if possible, a technical problem confronting the Oakland plant. His presence in Oakland was considered temporary by both his employer and himself. While in Oakland he was injured and medical services were rendered to him by several physicians. The insurance company carrying Tator's employer's workmen's compensation insurance in California refused to pay any compensation or to pay the physicians, on the ground that Tator was a *Massachusetts* employee and, hence, was only entitled to receive compensation in *Massachusetts* from the Massachusett's insurance carrier of Tator's employer. If the insurance company's position had been sustained, it would have meant that Tator's physicians would have had to proceed in Massachusetts to collect, if possible, their compensation. The California Supreme Court, however, held that it would be obnoxious to the public policy of this State to deny persons who have been injured in this State, although residents of another state, the right to apply for compensation, when to do so might require physicians and hospitals to go to another state to collect charges for medical care and treatment given to such persons. It was, therefore, decided that Tator was entitled to compensation and that his physicians were entitled to be paid in California.

This decision is so important to the medical profession that, at the risk of repetition, portions of the court's opinion will be quoted:

Upon the principles which have been stated and applied in these cases, Mr. Tator cannot recover compensation in California unless this State has a governmental interest in the controversy superior to that of Massachusetts. At the time of his injury, Mr. Tator was a resident of Massachusetts. He was employed there, and was subject to the direction of officers of the employer there located. His salary was paid to him in that state, and he had come to California only on a specific errand for his employer. Under these circumstances the interest of California, like that of New Hampshire in the Clapper case, *supra,* is only "casual" unless there are other facts upon which a governmental interest may be based. It is urged that this interest may be found in the medical and hospital expenses which were incurred in this State and had not been paid at the time of the hearing.

The modern view that the cost of industrial injuries is properly a part of the expense of production underlies all workmen's compensation laws. (*Western Ind. Co.* vs. *Pillsbury,* 170 Cal. 686.) The public has a direct interest in the results of industrial accident. When the injured employee had only a right of action for damages, he too often became an object of charity. Even under present laws the public bears some part of the expense of such accidents in addition to the amount which is added to the cost of manufacture. The public, therefore, is vitally concerned to see that adequate medical care is furnished to those injured.

This court has said: "As a practical matter, injured employees as a class will receive better and more willing medical service if remuneration for such services from an employer or insurance carrier is assured to doctors and hospitals than in instances may arise in which, if an employee neglects to file a claim for compensation, after the services have been rendered, such doctors and hospitals may be required to look only to the injured employee for compensation. It should be borne in mind that the medical, surgical and hospital treatment which is intended to be assured to injured employees as one of the items of their compensation by the Act, will be more certain to be furnished if doctors and hospitals are assured of certain remuneration for their services." (*Independence Indem. Co.* vs. *Indus. Acc. Com.,* 2 Cal. (2nd) 397, 404.)

The public policy of California upon this question has been clearly and positively stated in the Constitution, the Workmen's Compensation Law which was enacted pursuant to it, and the decisions of this court. It would be obnoxious to that policy to deny persons who have been injured in this State the right to apply for compensation when to do so might require physicians and hospitals to go to another state to collect charges for medical care and treatment given to such persons. Under these circumstances the governmental policy of California weighs more heavily in the scale of decision than the law of Massachusetts, and the conflict in laws must be resolved in favor of the state where the injury occurred.

The award is affirmed.

SPECIAL ARTICLES

SOME LOS ANGELES COUNTY HOSPITAL PROBLEMS: COMMENT*

Most members of the Los Angeles County Medical Association are aware that during the week just passed the newspapers have carried a series of reports referring to the Los Angeles County Hospital, founded on an editorial in the February OFFICIAL JOURNAL of the California Medical Association (on page 73), which in turn was based on an article in that issue (on page 97), contributed by your speaker.

It may be assumed, therefore, that the subject upon which further comment will now be made is not entirely new.

Some of the special issues involved concern matters such as the following:

The types of patients who are admitted to the County Hospital.

The bills which are rendered to them, after they leave the institution.

* Read by George H. Kress, M.D., Los Angeles, at the general meeting of the Los Angeles County Medical Association, on February 17, 1938.

For other comment on this subject, see February issue of CALIFORNIA AND WESTERN MEDICINE, on pages 73 and 97, and in this issue, on page 156.

The nature and fairness or unfairness of the Los Angeles County Hospital's fee bill for hospitalization services.

The misrepresentation in the statements rendered, which give the impression that professional care, rather than hospitalization, is being charged for.

The fact that the bills and legal demands are rendered not only to near- (medical) indigents, but to proved indigents.

The blunt legal language used in the demands for repayment to the county rendered to indigents.

The system of making indigents, or near-indigents, sign promises to pay, and of making liens on insurance policies and other equities in any small properties of these poverty or near-poverty stricken persons.

The follow-up system used by the County's Collection Bureau, when it makes it demands for repayment, on the indigent, and medical- or near-indigent groups.

* * *

Our own attention was directed to all this about October last, when a laborer, who occasionally worked for me, showed a statement for $31 or so, sent to him to cover his young son's stay in the hospital.

This man cannot speak English, has a wife and three minor children, and in his jobs as a day laborer probably cannot average more than $70 a month. On this amount he must rent a house, clothe and feed five persons. In response to my inquiry, the officials wrote that nothing could be done in his case, and suggested that this hard-working, honest man should arrange to pay back one dollar a month.

To me such a request or demand (to the Mexican laborer, equivalent to a demand) did not seem a fair proposition from the great county of Los Angeles.

In discussing the matter with colleagues, my attention was called to other even more aggravating cases: one especially glaring example being that of the woman for whom a cesarean section had been necessary, and who received a bill from the county for $136.80 to cover a single operating room use in the Los Angeles County Hospital.

In the meantime, sensing that a system was in vogue in the Los Angeles County Hospital with which members of the medical profession would not be in sympathy were all the facts known, correspondence was started, as given in the exhibits of the article which appeared in the February issue of California and Western Medicine.

In the limited time at our disposal this evening, it is not possible to go into details about all this. As was stated in the public press on Saturday last, February 12, a hearing was called by Supervisor Gordon McDonough, to which were invited representatives of the County's Charities, Legal and Auditing Departments, and also members of the Executive Medical Board of the attending staff. The newspapers had previously printed five topics which would be discussed. The County Counsel read the joint report prepared by his own and the County Hospital departments on the aforesaid topics. Anticipating what would happen, we also prepared and read the following report, and this I shall now offer again, because it comments on a few of the questions at issue.

* * *

[MEMORANDUM SUBMITTED ON FEBRUARY 14, 1938, BY DR. GEORGE H. KRESS, ON PRESS ITEMS CONCERNING THE LOS ANGELES COUNTY HOSPITAL, WHICH WERE PRINTED IN THE NEWSPAPERS OF SATURDAY, FEBRUARY 12, 1938

"Permit me to state at the outset that the twenty-page presentation of the Los Angeles County Hospital Collection Bureau problems, which is printed in the February issue of the Official Journal of the California Medical Association, practically outlines some of the major issues under consideration.

"I may add further, that no statements thus far appearing in the public press, presumably from interviews with county officials, lead me to think that any retraction should be made on what was printed in the State Medical Association's Official Journal.

"Allow me to say, also, that the Los Angeles County Hospital problems, to which attention has been called, are too big and altogether too important for possible solution at any single, or even a series of conferences such as this morning's session will probably be. What is needed, in the premises, are not merely opinions of interested parties, but rather the presentation of factual information secured after proper investigation by competent, impartial persons, to show whether the conditions complained of do, or do not exist.

"Let us take up, now, for consideration the five topics which Saturday's press announced would come before this February 14 conference body:

• • •

"Topic One: 'The Appellate Court decision in the Goodall vs. Brite case in Kern County, defining the county's responsibility relative to the operation of county hospitals and the fixing and collecting of fees.'

"Comment: The Kern County Hospital Appellate Court decision embodies, under item 8, its injunction provisions. None of the legal authorities of Los Angeles has given us thus far any specific references in the text of the Appellate Court decision which affirm that it is mandatory to send bills for board, room, and nursing (hospitalization services) to every indigent patient, and it is our own opinion and also that of friends in the legal profession that there is no mandatory legal authority for such bill-sending.

"Permit us, also, to call the attention of this conference group of county officials and attending staff representatives to the fact that we have with us this morning Mr. R. E. Heerman, present superintendent of the California Hospital of Los Angeles and a trustee of the Associated Hospitals of California, who was president of that organization when it appeared before the Fourth District Appellate Court on behalf of the respondents in the Kern County case. Also there is present Mr. Howard Burrell, who, as a 'friend of the court,' submitted the briefs on behalf of the Associated Hospitals of California. If this conference desires expert and legal opinion on hospital matters, why not give Mr. Heerman and Mr. Burrell the privilege of the floor and let them answer questions?

• • •

"Topic Two: 'Types of patients admitted at the General Hospital.'

"Comment: Any statement by the County Hospital authorities on this subject should be in detail and in writing, and should specifically comment on the hospitalization of:

1. Totally indigent citizens;
2. Partly or medical indigent persons;
3. Non-indigent patients; and also on
4. County employees; and on
5. Industrially injured citizens.

"The statement by the hospital authorities should be comprehensive and accurate, and indicate the approximate number of patients coming under each of the above groups, who were admitted during the last year or so.

"The admission requirements, likewise, as well as the types of prior or subsequent social service reports on applicants, and the manner in which the above classes of patients are tabulated in the County Collection Bureau, are matters worthy of meticulous study and report. No brief verbal statements concerning these matters will suffice.

• • •

"Topic Three: 'Comparison of charges for service with those of private hospitals.'

"Comment: In the Saturday press items, County Hospital Superintendent Gray is quoted as giving, as the estimate of himself and his associates, the figure of $6.39 for a private hospital ward bed, as compared with $3.81 per day for a ward bed in the County Hospital.

"In regard to the average ward rate of the accredited private hospitals of Los Angeles, why not find out, first, whether what is called the ward rate per day in the County Hospital includes all items of overhead which private hospitals must meet, such as:

"Interest on capital investments (Los Angeles County probably having about $20,000,000 of capital investment in the County Hospital.)

"Insurance (even though Los Angeles County insures itself, when costs are estimated that item should be included).

"Depreciation, etc.

"In other words, when ward rates are compared between the Los Angeles County Hospital and private hospitals,

it is important to learn whether the same thing is always being talked about. Otherwise, the conversation may merely be a discussion of misinformation. A very explicit statement in writing by the proper County officials is desirable on these points.

"Here, also, why not call in the local representatives of the Associated Hospitals of California and hear their opinions? These taxpaying hospitals do much charity work, and if their rights are being encroached upon because the County Hospital admits pay patients who are not legally entitled to County Hospital care, that matter should be carefully investigated. We feel certain that the Associated Hospitals of California will be happy to coöperate in these matters.

"Concerning Superintendent Gray's figure of $3.81 as the County Hospital ward rate per day, as noted in Saturday's press items, how is this to be reconciled with the fee table which his office recommended the Los Angeles Board of Supervisors to adopt on June 29, 1937, and which contained rates varying from $3.17 to $8.54 for a ward bed per day?

"The question also arises: If the cost in the County Hospital is only $3.81 per day per ward bed, by what legal right can bills be rendered for more than this amount, and, especially so, to indigent citizens? To ask recipients of public aid for more than actual costs would seem to be a violation of State law.

"In the fee tables at our command at the time of this writing, we note among private hospitals in Los Angeles the following daily ward rates: Children's Hospital, $4; St. Vincent's Hospital, $4; Queen of the Angels Hospital, two-bed room, $3.75 to $4; French Hospital, $3.75; California Hospital, children's ward $3.50, four-bed ward $4; Methodist Hospital, $3.75; Cedars of Lebanon Hospital, $4.50; Hospital of the Good Samaritan, industrial floor, two-bed room, $4 to $4.30 per day.

"In Saturday's press items, the Medical Director of the County Hospital, Doctor Berman, commented upon a patient who, in the article which appeared in the Official Journal of the California Medical Association, was given as a fee table example, and who received an itemized statement having as one single charge the following:

October 5, 1937. Operative—Cesarean section.....$136.80.

"In regard thereto, Doctor Berman was quoted as saying the patient was in the operating room for three hours and that 'in a private hospital her bill would have been more than $1,000.'

"If Doctor Berman was correctly quoted (and the item appeared in more than one newspaper), his statement must sound absurd to all physicians who are familiar with the charges for use of operating rooms (and operating-room expenses, not professional services of attending staff members, are the things for which the county of Los Angeles has a legal right to make charges).

"As a matter of fact, an average charge for the use of an operating room in a private hospital in Los Angeles for a minor operation would be $7.50 to $10, and for a major operation $15 to $20. If the operation lasts longer than one or two hours, then sometimes an extra charge of $1 to $2.50 or so per hour is made, so that if Medical Director Berman now states he meant 'professional services,' then since he, himself, has never been in private practice, it may be proper to inform him that if a physician charged $1,000 for an operation to an indigent person, and the matter were called to the attention of the Los Angeles County Medical Association (in case the doctor was a member), such a member would be haled before the constituted authorities for disciplinary action.

"Doctor Berman was also quoted as saying that the charge of $136.80, for a single session in the operating room, covered not only the cesarean section but several operations at the same time, etc. However, the bill stated the charge of $136.80 was for aid by the Department of Charities on date of October 5, 1937. It may be proper to add that Doctor Berman's method of describing an operation in terms of multiple operations is quite unusual, and it would be interesting to have him tell the medical members of the Executive Board more about these multiple operations and why they add materially to the overhead cost in the 'use of an operating room.'

"Topic Four: 'Explanation of the accounting system as established at the hospital by the County Auditor's staff.'

"Comment: Here also we believe an exact and comprehensive statement in writing would be quite in order; and appended thereto should be copies of all the different form follow-up letters sent to indigent and other patients, used during the last six months, as well as copies of memoranda or other instructions given to field representatives of the County Collection Bureau, who are sent out to interview former patients about payments due, etc.

• • •

"Topic Five: 'Collection policy of the County Charities Department in collecting for service rendered patients at the General Hospital.'

"Comment: What has been said under Topic Four applies here also."

• • •

"In conclusion, may we submit that one way to get at the bottom of this intricate matter would be to send out a questionnaire letter, properly phrased, to every one of the 32,469 former patients of the Los Angeles County General Hospital who received hospitalization care during the period July 1, 1937 to December 31, 1937, inclusive, the aforesaid bills totaling $2,366,779.30, or an estimated total of $4,733,588.60 for the year! From letters and telephone messages which have come to the Los Angeles County Medical Association during the last week, we believe such an approach would bring out some very illuminating facts and other information.

"Supervisor McDonough, permit me to remind you and the members of this morning's conference that in our correspondence with the County Hospital and Collection Bureau officials, as carried on during the last four months, we stated at the outset and subsequently, that it was our purpose to discuss this matter editorially, with information appended, in the Official Journal of the California Medical Association.

"More than five hundred members of the Los Angeles County Medical Association gratuitously give, each year, to the indigent sick, and taxpayers of the county, professional services having an estimated money value of more than two million dollars ($2,000,000). This humanitarian donation by the medical profession to the sick poor of Los Angeles County entitles its members to a careful hearing when they plead for kindly hospitalization care on behalf of indigent citizens, and also for a strict adherence to the State laws governing county hospitals."

* * *

The above concludes the written statement presented on Monday last. At the close of that meeting, Supervisor McDonough appointed a joint conference group of county officials and the Executive Medical Board of the staff to make a further study of the problems. What will result from the future meeting or meetings of this conference group we, of course, do not know.

To Summarize: In common with many other physicians familiar with the situation, we believe the printed articles already referred to were more than justified; and it is our further belief that some of the evils complained of will be remedied as a result of the publication.

Certainly, at least one good result has already been attained, namely, that of acquainting the more than two million citizens of Los Angeles County with the fact that the medical profession of Los Angeles annually donates to the poor who are sick, and to the taxpayers of our county, professional services having a money value of more than $2,000,000 (or about the same that the entire city raises for its yearly Community Chest goal). As a result of that publicity, we are in much better position to obtain a yearly printed report of the professional work of the staff, an effort which during the last ten years has failed of accomplishment.

The legal authorities of the county also acknowledged at the end of Monday's meeting that there were no specific statements in the Kern County Hospital-Appellate Court decision making it mandatory to send statements for hospitalization to indigent citizens.

Before the investigation is finished we hope to see an explicit set of rules promulgated by the county authorities that will clearly demark, in compliance with provisions laid down in the State law, the following:

The type of citizens who are eligible to admission and the type to be excluded in the Los Angeles County Hospital;

A more equitable fee table for County Hospital hospitalization charges, and the adoption of a system in which the patient or a legally responsible relative will be told, at the time when the patient is admitted, concerning the ward rates per day and possible accessory costs of hospitalization care.

Cessation of, shall we say, what is almost a dishonest practice of the County in giving the impression to these indigent sick persons that the bills are for professional care;

And to bring about also a somewhat kindlier follow-up system in the Hospital's bill-collecting methods.

Many other matters, each worthy of a separate text, might all be brought forward for consideration, and these may be discussed in the future.

945 Roosevelt Building,
727 West Seventh Street.

ADDENDA

LOS ANGELES COUNTY HOSPITAL: SOME SELF-EXPLANATORY LETTERS

In the February issue of California and Western Medicine, on pages 73 and 97, certain procedures in vogue at the Los Angeles County Hospital for some time past were discussed and admission requirements and other matters criticized. Supplementary to last month's articles, and comment on page 156 in this issue, the following letters, presenting an interesting story, are taken from a large number received after the above referred to articles were commented upon in the daily papers:

* * *

[An Opinion of the Legal Counsel of the Associated Hospitals of California, with Special Reference to the Appellate Court Decision in the Kern County Hospital Case]

(COPY)

Los Angeles, California,
February 14, 1938.

To the Board of Supervisors
of Los Angeles County,
Los Angeles, California.
Gentlemen:

The undersigned are the attorneys for the Association of California Hospitals. This Association represents the interests of the private hospitals of the State of California.

We understand that there is pending before your honorable board, or a committee thereof, among other things relating to the Los Angeles General Hospital, two questions:

1. The type of patients admitted at the General Hospital; and
2. The matter of the accounting system involving billing and liens.

As to the first, the case of *Goodall* vs. *Brite*, 11 Cal. App. (2d) 540 (decided January 30, 1936),* establishes certain principles:

That there are three classes of persons who may claim the right to be admitted to the Hospital:

1. Indigents.
2. Persons of some means, but not sufficient to pay for maintenance in a private hospital after providing for those who legally claim support.
3. Emergency cases, regardless of the ability to pay.

The decision, of course, is definite that persons who are able to pay should not be admitted, and that due inquiry and investigation should be made to ascertain the facts. We assume that the Board of Hospital Management has conformed its practice to the principles laid down in this case. We also assume that the Board of Supervisors, in conformity with Sections 2576, 2600, and 2603 of the Welfare and Institutions Code, has established regulations in respect to the amount of property and the income, and the obtaining of liens upon property of patients falling within the second classification above set forth.

In regard to the matter of accounting, and particularly billing patients entering the County Hospital:

As to persons falling in Classes 2 and 3 above, no particular question is presented. Obviously, the hospital management should bill and attempt to collect from persons falling within these two classes. In regard to indigents having no present property, we find no requirement in the statute that they should be billed. We recognize, of course, that under Section 2603 the county has the right to recover a reasonable charge for services rendered if the person should at a future time acquire property. We assume that this section is the basis for the existing practice of billing indigents. As a practical matter, some considerable cost is involved in billing a class of patients from whom no return can be expected, and it would seem soon enough to go to the accounting and billing expense when the management has reason to believe that the patient has property or income from which payment can be made or collected. We do not believe that the taxpayers should sustain the cost of an expensive accounting and billing system in regard to all of the indigents, when as a matter of fact in only a very small percentage of cases will the county be able to collect anything. We believe it proper to consider the effect upon the needy if they are billed and pressed to pay. To emphasize this feature may engender the belief that the social function and service is secondary, and that collection is the primary concern.

1175 Subway Terminal Building,
Los Angeles, California.

Yours very truly,
Musick and Burrell.
By Howard Burrell.

* * *

[Another Legal Opinion, from a Lawyer Friend, in Which Comment Is Made on the Interpretation of the Appellate Court Decision in the Kern County Case]

(COPY)

"Dear Doctor:

"What is published as the decision or opinion of the court is made up of two parts: First, a statement by the court of the essential facts of the case as presented by the parties, with comments and reasoning of the court pertaining to them. Second, the judgment of the court. It is the judgment of the court that tells the parties what they must and what they must not do.

"In the present instance, the judgment of the court is found in the eighth section of the published decision, in two paragraphs, each beginning: 'It is therefore ordered, adjudged and decreed." The first of these paragraphs orders the defendants in this case to desist from admitting to and receiving as patients of the Kern General Hospital any person who, after due inquiry and investigation, is not found to be 'an indigent person' as defined in the decision, except under certain circumstances stated in the judgment, under which a non-indigent person may be admitted; or 'a dependent or partially dependent person *in case of emergency*, or who is found, after due inquiry and investigation, to be a person who is himself, or has a relative or relatives legally liable for his support, able to pay for and obtain proper and necessary medical or surgical or hospital care or treatment or services for himself elsewhere than in the county hospital' except as otherwise specified in the judgment. The judgment specifically defines certain classes of persons who should be admitted, including 'an indigent sick or dependent poor person' and 'a needy sick and dependent or partially dependent citizen in case of emergency.' I have underscored *'in case of emergency,'* not because it seems to have any specific applicability to the controversy in which you are now engaged, but to call your attention to it as being obscure in meaning in its present setting.

"Certainly, nothing in the judgment of the court even suggests to a reasonable person any obligation on the part of the defendants to collect from indigent persons or dependent or partially dependent persons, anything whatsoever.

* Editor's Note.—The full Appellate Court decision in the Kern County Hospital case is printed in full in California and Western Medicine, February, 1938, on page 106.

"What the court did say was:

In their rules of admission they [the Board of Supervisors] should have the power to provide for the payment for care by those not financially able to secure hospitalization in a private institution, the amount to be paid to be determined to its maximum by the cost to the county of hospitalization of each individual patient and charged to the patient on his ability to pay.

"One who is inclined to quibble might claim that the phrase 'the amount to be paid to be determined to its maximum by the cost to the county of hospitalization of each individual patient and charged to the patient on his ability to pay' is separate and distinct from the clause in the same sentence that 'they (the Board of Supervisors) should have the power to provide for the payment.' Any such construction, however, unless there is some question of the legal authority of the Board of Supervisors to provide for payment, would clearly leave meaningless the statement in the opinion of the court that the Board of Supervisors, in their rules of admission should have the power to provide for payment. The court does not say power to *compel* payment, but power to *provide for* hospitalization of each individual patient should be 'charged to the patient on his ability to pay' it clearly implies that if a patient has no ability to pay, nothing should be charged to him, that if he is able to pay, say $1 or so a week, only that amount should be charged to him and to the extent that such a patient is able to pay only less than the entire cost of hospitalization *in his own particular case,* the Board of Supervisors should in their rules of admission provide for payment of the balance. Of course, here I come back to a clause that I have stated above, which makes this reasoning dependent on the legal authority of the Board to use public funds to pay the cost of hospitalization of totally indigent persons and the balance of the cost of hospitalization of persons able to pay only in part for the services rendered. Such authority seems to be clearly implied in the opinion of the court. . . .

"Personally, it looks to me as if the Board of Supervisors, . . . the defendants in this case, had any thought that the judgment of the court was in any way obscure, the proper course would have been for them to have applied to the court for instructions. The fact that they have elected to charge persons for services amounts that they knew such persons would never be able to pay, and the fact that they have under the pretended cover of a court order spent public money in efforts to collect accounts which they knew were uncollectible, without asking further instructions from the court, would seem to me, in view of the clarity of the court's decision and judgment, to come very near to exposing them to punishment for contempt of court."

* * *

[Letter from a San Francisco Colleague]

(COPY)

San Francisco, February 15, 1938.

Dear Doctor:

The profession of the State of California owes you a debt for the amount of work you have put in, in attempting to straighten out the whole subject of county hospitals, by taking up the situation in Los Angeles.

According to the decree of the Appellate Court, Fourth District, confirming the opinion of Judge Van Zante, public hospitals in California cannot hospitalize non-indigent patients. As a matter of fact, at least thirty of them do so, and the abuses incident to this have led to a strong feeling on the part of Farm Bureaus, whose bill before last year's legislature, to open the county hospitals to everybody, was the result. I was asked to speak before the National Farm Bureaus in Pasadena the spring before, but to avoid the subject of the county hospitals. This latter I declined to do, because I felt that the Farm Bureaus were going at the thing in an entirely wrong way. We have not quite one county hospital to each county, but of the fifty-seven hospitals only sixteen are Class A, and four are Class B. Most of the rest are scarcely decent, and some of them are a disgrace to modern civilization. They are unworthy of the name "hospital."

In view of the fact that county hospital construction is passing through the same evolutionary stage that public school construction is passing through in this State, and we point with equal pride to some of our magnificent county hospitals as well as our public schools, I think it is fair to follow the possible developments ahead a little, and examine the subject carefully to see if the time has not come when the county hospitals should all be raised to Class A or B standard, and the situation which holds in the Buffalo General Hospital be made to apply. Furthermore, these hospitals could then become the health centers for the counties, which in all but the large cities are indispensable. In Buffalo the Public Welfare Board, and not the Supervisors, determine who shall be admitted to the hospital, and what that individual shall pay, if anything. He has the right to be cared for or operated upon by his own family physician. What he pays for his bed is a matter of record with the Commission, but what he pays his doctor is entirely between the doctor and himself. In this way when patients are embarrassed for money to meet emergencies they can still be dealt with as independent factors in the community, and not as paupers or indigents. They are not subject to the care of such glorified collection agencies as have been brought into operation in a number of our cities, and the feeling on the part of the doctors that they were rendering a charitable service to the people.

There have been objections to the Government entering into medicine at all, but I think that is felt mostly by unthinking physicians who would be loath to do without Government standardization in much that pertains to medical education, drugs, and a great deal that enters into successful practice.

Six years ago the Committee on the Costs of Medical Care called attention to the fact that, of the 3,078 counties in the United States, over 1,000 had no county hospitals, to say nothing of the extremely poor standards of many then in existence. An opportunity was presented at that time, during the depression, to seek Government aid in a health program, to secure loans for suitable county hospitals, with the provision that they be operated under standards which a department of public health would lay down. The Government could not have used its project policy to greater advantage than to supply first-class county hospitals where they were needed. The Committee on the Costs of Medical Care showed that 73 per cent of the hospital beds in the country were tax-supported, and the rate of increase was over one per cent a year. In San Francisco, since that report, there have been over 1,500 new tax-supported beds put into use—in the Marine Hospital, the Veterans Facility, the top floor of the San Francisco General Hospital, and in the new hospital for the insane and cancer cases. This is an example merely of how surely the need for hospitalization is being taken over as a Government function.

It seems quite clear that the day of the private hospital is about over, as are private schools. A few will always exist and they will serve a good purpose, but steadily the work of each community will be done more and more in the large hospitals which are mainly supported by tax funds. Teaching hospitals will always exist. Heavily endowed religious hospitals are likely to continue, and such hospitals as our Southern Pacific Hospital for the care of industrial cases, will inevitably go on, but we should make the use of the beds in the tax-supported hospitals available to the public at large, and they should certainly be of use to the taxpayers. Your $18,000,000 County Hospital in Los Angeles, with its additional millions in equipment, presents a problem that might be applied to every community. It is a dreadful thing to the great working class to realize that 300,000 Mexicans and 60,000 negroes, who pay little or nothing in taxes, can be taken in, where a small wage-earner with his large family is ruled out. May I call your attention to the statement on page 9 of Los Angeles County's publication on budgets, to the effect that in that county a man with a wife and two children, earning $60 a month or less, is entitled to care in the hospital, but if he earns $61 he and his family are not entitled to it. I do not believe that that fact is known to the physicians in Los Angeles County, and I do not believe there is a single one of them who wants to earn any of that family's money which must go for rent, food, clothes, etc.

909 Hyde Street.

Very truly yours,

PHILIP KING BROWN.

[Letter from the East]

(COPY)

AMERICAN MEDICAL ASSOCIATION

Chicago, February 16, 1938.

Dear Doctor:

I have been much interested in the material that you have sent me pertaining to the hospital situation in Los Angeles. . . .

I have some very definite convictions about hospitals and hospital management, and one of them is to the effect that few hospitals with a capacity exceeding four or five hundred beds can be run economically or with the greatest possible efficiency. I believe that the excess machinery that is necessary to operate a tremendous institution sooner or later creates complications of very serious nature, and I do not think that dangers of this nature are at all reduced when the big institutions are owned and controlled by governmental agencies.

With most cordial good wishes, I am

535 North Dearborn Street.

Very truly yours,
OLIN WEST, M.D.,
Secretary and General Manager.

* * *

[Experience of a Long Beach Physician]

(COPY)

Long Beach, California,
February 14, 1938.

My Dear Doctor:

I have read with much interest some of your comments on the conduct of "Outdoor Medical Relief" and other charity work, both in and outside our County Hospital. I want to commend your stand in these matters. This whole county relief program has violated many of the fundamental principles of aid to the truly indigent. Its beneficiaries are the vast army of salaried employees. That department has become a veritable stench in the nostrils of honest men, both among the taxpayers and our profession.

Personally, I had little or nothing to do with this service until after the earthquake, when my Long Beach offices were wrecked and I took temporary quarters with one of my friends and opened a clinic in a building in Wilmington. Almost immediately I was asked by the doctors of San Pedro and Wilmington to take care of indigents (eye, and ear cases), referred by the Department of Outdoor Relief, at San Pedro and about the harbor region.

Very soon I discovered their rolls were being padded by dozens of able-bodied adults willing to take free medical care because the indigent "Joneses" were getting their's free. I remonstrated with the head of Outdoor Relief and attended one of the so-called staff meetings at San Pedro, which was addressed by three county agents who came to tell the Harbor District doctors that their medical care was costing the taxpayers too much, and that county funds were rapidly being depleted; that whereas $1,250,000 had been asked for, only some $900,000 had been allowed by the Board of Supervisors. When I asked why there was not some way of cutting down the overhead of the salaried group, they answered that this could not be done until at least 40 per cent of the present load was lifted. When I pushed the question as to why the load was not being reduced by the social workers, the meeting broke up and we had no further answers to questions. I then notified them to send to me no more able-bodied men and women for free medical care unless the case was an emergency. To this they paid no attention. Then I notified them again and began turning back such patients to them, only to find they were referring the same patients over to other physicians.

I then sent a similar letter to each member of the County Board of Supervisors. One of these reached Rex Thompson, who promptly wrote me demanding proof of my charges. I replied that I would be glad to furnish proof aplenty before the Board of Supervisors at any time he or they desired the matter openly discussed. To this he made no reply. However, within a week two hundred workers in his department were let out, but the system has not been very much changed, so far as I can see, and every now and then some big double-fisted oil worker, who has been employed at $8 a day, slides into the line at San Pedro and gets an order to come to the county service here. It is our rule to give them emergency care or fire them back with a letter demanding that such imposition on the taxpayers and the medical profession be stopped. These letters never receive any attention in the way of a reply. They evidently do not want to have the system disturbed.

So I regard your protest as both timely and very much to the point. If social service in this work amounts to anything and served the purpose for which it is intended, there would come at least a partial cure of these evils, some of which your letter has brought to public attention. I hope you will officially and otherwise keep this question in the public eye, and I will help you all I can to drive out the graft in this whole system and make the taxpayers' money go where it should go—to pay for needed medical services both in and out of the County Hospital, to the truly indigent.

360 Juniper Building.

Yours very truly,
FRANCIS L. ROGERS, M.D.

* * *

[Letter from a Santa Monica Physician, and Reply]

(COPY)

SANTA MONICA HOSPITAL, INC.

Santa Monica, California,
February 16, 1938.

Supervisor McDonough,
Hall of Records,
Los Angeles, California.

Dear Sir:

I have noted in the public press that you are heading the committee in regard to County Hospital affairs and have thought that you might want to get the ideas of executives of some of the private institutions in regard to the present controversy.

In my opinion, it is of a great deal of value to private institutions to have the county bill patients for the amount of their hospital care while in the institution. In my opinion, it is perfectly proper that even the indigents should know the approximate cost of what the taxpayers are giving to them. It makes the people of the county conscious of hospital costs, and I am sure we have less complaint about the costs in private hospitals when the costs in public hospitals are known.

To what extent the county shall go in attempting to collect these bills is, of course, a matter of wide difference of opinion. No doubt that when patients are well social serviced before admission to the County Hospital the amount of recovery through collections will be small. However, the knowledge that the county is going to make an effort to collect when the person's condition is such that they can pay, will act as a marked deterrent to people who are trying to get something they are not entitled to have. I believe that both the medical profession and the private hospitals are being benefited by an honest effort to collect bills from county hospital patients. It makes the patients more willing to try to take care of their obligations in private institutions, both to the institution and to the doctor caring for them.

If a real desire exists to try to reduce County Hospital costs, then it might be well to investigate costs incurred at the hospital by what may easily be an excessive amount of both diagnostic and treatment procedures made use of by the staff because it is a public institution.

I have no factual knowledge as to these costs, but from general information I think much might be done there to lessen the cost to the taxpayer. It is my great desire that we shall have a County Hospital second to none and that it shall give the indigents all that they need and are entitled to.

Very truly,
W. S. MORTENSEN, M.D.

* * *

SANTA MONICA HOSPITAL, INC.

Santa Monica, California,
February 16, 1938.

Dear Doctor Kress:

The above is a copy of a letter which I have sent to Supervisor McDonough and expresses my opinion in regard to the present controversy.

I feel that this is a matter that should be carefully considered.

Very truly,

W. S. Mortensen, M.D.,
Superintendent.

* * *

February 17, 1938.

Dear Doctor Mortensen:

Thank you for sending me a copy of your letter of February 16 to Supervisor McDonough.

If you will read carefully the article on page 97 of California and Western Medicine, I think you will note, as for instance on page 102, that I also believe in submitting bills to partly indigent (medically indigent) patients, and I would let these patients receive their bills while they were in the Hospital, just as you present your statements to your patients in the Santa Monica Hospital.

As regards billing of indigents, General Counsel Peart of the California Medical Association is of the opinion that an indigent is entitled to hospitalization service at public expense.

Reference to page 108 of the February issue, item 5, about the twenty-fifth line, you will find this explicit statement in the Kern County decision: "It is admitted that a resident pauper must be hospitalized at public expense."

When it comes to sending such an individual a bill, it is my opinion that, as I stated to the conference committee on Monday morning in the office of the Board of Supervisors, such statement could be sent in the form of a courteous letter somewhat as follows:

Dear Sir:

This is to remind you that during the period ——— to ——— you were a patient in the Los Angeles County Hospital. The hospitalization given (board, room, and nursing) made it necessary for the taxpayers of Los Angeles to expend the sum of $——— for your care during the aforesaid period. There was no charge for the professional services of attending physicians and surgeons, who donate their services to the sick poor.

It is our hope that you will recognize that this is an obligation on your part and that in due time, if your means permit, you will make an effort to pay the County of Los Angeles in whole or in part for the services above rendered.

Very truly yours,

Department of Charities, County of Los Angeles.

By ———————

* * *

I am of the opinion that when you look into this matter as fully as I have, you will find that you have very little difference of opinion on some of these fundamental issues.

With best personal wishes, as always,

Cordially yours,

George H. Kress, M.D.

* * *

[Letter from a Los Angeles Physician]

(copy)

Los Angeles, February 18, 1938.

Supervisor Gordon L. McDonough,
501 Hall of Records,
Los Angeles, California.

My dear Mr. McDonough:

I want to report another victim of the abominable system used at the County Hospital, about which you see so much in the papers.

I have a patient, Mr. (name), an honest, reliable truck driver, who had a very severe bowel infection and a number of abscesses around the rectum. He had been sick for some time before I saw him and had had several operations, using up all his savings. I operated upon him on January 25, 1937, and have taken care of him ever since, for which, altogether, he has paid $15.

Last summer it was necessary to have some x-ray pictures taken, for which he was unable to pay. He was also under the care of Dr. E. L. Armstrong, who suggested that he go to the General Hospital for the x-rays and check-up, and he was given a letter to the hospital stating he was unable to pay anything.

When Mr. (name) entered the hospital there were many people in the admitting office, all of whom were asked to sign a printed form, but when he presented Doctor Armstrong's letter he was admitted without signing anything, so he assumed there would be no charge. He was in the hospital two weeks.

He had been home a short time when a representative of the hospital came with a bill, charged at the rate of $4 a day. As he had no money the representative asked to see his insurance policy, saying they would keep it at the hospital but he could get it whenever he wished. Mr. (name) was asked to sign a form allowing the hospital to collect the $20 payable monthly on the policy, but this he refused to do, stating he needed the money to live on. He did, however, sign the form with this phrase crossed out. However, a short time later the representative again called stating Mr. (name) had signed the wrong form and asked him and his mother to sign another form, which they did.

The first of the month, following this last visit, the insurance check did not arrive and, on checking with the company, Mr. (name) was advised that the check had been sent to the hospital. He called the hospital and insisted he needed the money, which they agreed to send to him. After approximately three weeks, or on December 22, they sent their check for $20. In January they sent their check on the 26th to cover money they collected on the first. They, therefore, kept the money almost a month before sending it to the patient, and they are now nearly a month behind again.

Now I call this a rotten system, as the County Hospital is supported by the taxpayers for the benefit of the indigent, and if this boy is not an indigent and a victim of circumstances, I do not know of any.

As a doctor, taxpayer, and voter, I hope the Supervisors will do something to correct this condition.

Yours very truly,

William H. Kiger.

* * *

[Samples of Letters Received from Former Patients of the Los Angeles County Hospital]

(copy)

Los Angeles, California,
February 9, 1938.

Dear Sir:

I have just finished reading your statement regarding the Los Angeles County Hospital, and wish to extend my congratulations to you in bringing this matter to the attention of the public. This insidious evil, cloaked under the guise of charity, is indeed a reflection on our city, county, and state.

Several years ago my wife, who was at that time a widow, supporting two children and an invalid mother through her own efforts and without any outside assistance whatever, was compelled, through lack of finances, to place her mother in the county hospital for treatment. I, myself, visited her mother before our marriage, and I was very much impressed with the lack of care and attention which she received while there.

Later, after our marriage, it became necessary for my wife to undergo a serious operation, for which I arranged to be performed at the Methodist Hospital. The difference in the service and attention she received there could not even compare with what her mother received at the county hospital, yet the daily rate was considerably less than that charged for her mother, who is now deceased, and for whose care she recently received a bill for the sum of $199. The itemized bill includes charges for clinical visits, and x-rays which she was given without her knowing what it was all about, as she was Italian and could not understand English. Furthermore, she was told to return to the clinic weekly and was not informed that there would be any charge for this service or what the charge would be. If this is justice, I do not see why I cannot dump a load of manure on the grounds of the county hospital and later charge whatever I may want to for same, although it was not ordered. Neither were the x-rays, etc., claimed by the hospital, ordered. Furthermore, it certainly seems to me that an institution that was originally built out of the taxpayers' money, and is exempt from taxes, and also receives approximately 21 cents from every dollar of tax receipts, plus the purchase saving that a county institution can make, should be able to operate much cheaper than a private institution that has to contend with all of the above, plus yielding a fair profit for its investors.

Well, at least I have gotten that off my chest. Should you be interested in further details regarding my wife's mother's case, I will be more than glad to furnish you with complete data on same.

Thanking you again for your fortitude in expressing an opinion that, I am sure, is shared by a great majority of the citizens of Los Angeles County.

I wish to remain

Sincerely yours,

(Name)
(Address)

* * *

(COPY)

Los Angeles, California,
February 10, 1937.

Dear Sir:

The article printed in the Los Angeles *Times*, "Hospital Cost Inquiry Slated," concerns me very much.

On (admission date) I brought my boy to the Los Angeles County General Hospital with infantile paralysis. He was discharged on August 13, for which I received a bill for $153.72. At the time, my husband wasn't earning enough to support the family with food and shelter. Not being able to pay, I was asked to surrender his insurance policy, which has been borrowed on to keep from lapsing. When I asked to have time to inquire about signing it over to the county, I was told that the treatments would be stopped. Naturally, I signed it over quick.

It seems to me we could have gotten service for that or a lot less in a private institution.

I hope this letter could be of some help to you in this investigation, and in the future help a lot of unfortunates.

Very truly yours,

(Name)
(Address)

* * *

(COPY)

Los Angeles, California,
February 18, 1938.

Dear Sir:

My wife was pregnant, so went to the White Memorial for prenatal care. She made one visit and was told she had high blood pressure and that she must go home and stay in bed, which she did, the doctor coming out several times a week to see her. Her blood pressure went up to 210. As I was unemployed and could not afford to pay for her treatment, she was sent to the General Hospital as an emergency; that was on October 19, 1937. Three days later the baby had to be taken, as my wife had toxemia. The baby died on October 27, five days after birth. My wife (name) was discharged from the hospital on November 1, 1937, which made her stay in the hospital thirteen days. A week later a man called at my home from 434 South San Pedro, Room 210, asking for my wife's insurance policy, or she couldn't get any more treatment from the hospital. He stated it was the law of California for them to hold the policy until all payments had been made. I told him I wanted to pay my bill and would make payments as soon as I was able, but would not surrender the policy.

Dr. (name) from the Clinic ordered my wife in the hospital for a kidney treatment, and was to stay in the hospital for one or two nights. She had a bed-waiting list and was told to come in January 9, 1938. Upon arrival at the hospital the social worker refused to let her enter the hospital because of my refusal to give them the insurance policy. I told them I was on relief, and I still am on relief, and my wife is sick with kidney trouble and high blood pressure and I can't afford to pay a doctor. Now, my wife's bill for thirteen days is as follows:

October 19 to November 1, 1937—Obstetrical ward (adult), thirteen days at $4.46—$57.98.	
Operative—Normal delivery—$31.23.	
October 22 to October 27, 1937—Obstetrical ward (infant), five days at $1.00 per day—$5.00.	
October 27, 1937—Mortuary service, $2.91—$7.91.	$89.21
	7.91
	$97.12

This may help you understand my case. Thanking you, I remain

Yours truly,

(Name)
(Address)

(COPY)

Los Angeles, California,
February 9, 1938.

Dear Doctor:

I noticed the article printed in the *Daily News*, February 9.

I took my wife, Mrs. (name) to the General Hospital on January (date). She had pneumonia, and is still there. She told me that they had made her sign away every right in the world, and she didn't know what it was all about. At that time she was delirious most of the time and didn't know or care what she was doing. If they would just leave her alone.

Yours truly,

(Name)
(Address)

* * *

Sunday, February 20, 1938.

Dear Doctor:

Am writing you to tell you how much I appreciate the fight you are putting up for the poor people who are compelled to go to the County Hospital for aid, and they go there because they haven't the means to go anywhere else.

My husband had cancer of the larynx. He became so violently ill one night, so I had to call the ambulance and have him taken to the County Hospital. It was around six o'clock. I sat and waited until 9 p. m. until he was assigned to a ward. The next morning I received a telegram from my husband to come and get him, so I immediately went to the hospital. He told me he lay there from 9 until 2 a. m. and he couldn't even get a drink of water or a match to light a cigarette. I begged him to stay. They put him in a ward with six other patients. It was in the month of July, and the odor was so terrible in that ward, I don't know how he ever stood it; and for this service I am charged $4 per day. The first bill I received was for $115. Then when they found out my husband had a little money coming through an estate, they sent another bill in for $150, charging $35 extra for treatments and ambulance, and that claim they put in against the estate. They burned his throat so unmercifully that he was worse off than before he went to the hospital, so I brought him home and cared for him, He was in such terrible pain I kept him under morphine until he passed on September 22, 1937.

I lost my job after ten years of service with the May Company just the time I needed it most, so I had to borrow money from a friend, to see me through, and this debt I still owe. By the time I pay funeral, doctor bill, and my friend, there will be very little left, so I feel it very unfair for the County Hospital to put a bill charging extra for all treatments, besides $4 per day. Do you think it advisable to see the superintendent of the hospital personally and tell him the circumstances, or will I be compelled to pay the bill extended me. I would appreciate hearing from you, and do keep on fighting. I glory in your spunk. Many, many people read your article in the paper and many of my friends called me and they all think you are doing a great work. After all, what is the County Hospital for? The way it's run now is far from being a charitable institution.

There is a lady living at this same address. She went on relief in 1936. They made her sign over everything she owned, which were two lots—one in Compton and one in Harbor City. The valuation on these lots are, at the most, worth about $200 each. She gets old-age pension now (she's 73 years old) and she had to go to the County Hospital for a glaucoma on her eye. They removed her eye, and I am enclosing a letter which she received which means that her hospital bill will be charged against those lots the county now holds. I went to the county tax office and inquired as to what right she would have as to sale of these lots, and I was told that she would have to pay back every cent she received from the county while on relief, plus taxes, and that means they keep the lots, and this hospital bill is added on, so what chance has any poor devil; in fact, she is paying for all services rendered.

I hope, Doctor, I haven't bored you with all this trouble. You are so grand to take up this fight, and I only hope you will carry on, and you will win out for the betterment of the less fortunate.

Very sincerely,

(Name)
(Address)

Please send back letter enclosed.

(COPY OF DEPARTMENT LETTER REFERRED TO ABOVE)

COUNTY OF LOS ANGELES
DEPARTMENT OF CHARITIES

Los Angeles, California.
(Date)

Address reply to:
Investigations and Searches,
210 Welfare Building,
434 South San Pedro Street.

In re: (name)
Col. File (number)

(Name)
(Address)

We have been notified that hospital care was given you from (date) to (date), 1937, at the Los Angeles County General Hospital.

This is not a demand for payment, but merely to advise that the care received is accruing at full cost charge under lien signed by you on (date).

Very truly yours,
DEPARTMENT OF CHARITIES
COLLECTION DIVISION
By (signed—rubber stamp)
(Name)
Director, Investigations and Searches Section.

(Rubber stamp notation: Important always mention name and number of this account in your reply.)

* * *

(COPY)

(Copy of a memorandum dated February 21, 1938, regarding attached County Hospital statement, brought in by a relative.)

In re: (name and address)

Mr. (name) brought these bills. They have gone back seven years for the bill against Mrs. (name), and two years each for her two children.

She is a widow with six children, and Mr. (name) says she has all she can do to feed and clothe the children.

He also asked if this seven-year bill was not outlawed? A doctor's bill is outlawed in four years; but what about a hospital bill?

[Query.—If the present fee table of the Los Angeles County Hospital became legally operative on July 1, 1937, is there any legal warrant for sending a statement, based on that fee table, to a former patient of several years ago, at a time when present fee table charges were not operative?]

* * *

(COPY)

Statement
File No. ———

Aid advanced to (name)
Address ————
City ———
Aid advanced by LAGGH
Bill to: (name and address)

To County of Los Angeles—Department of Charities, Collection Division.
434 South San Pedro Street, Los Angeles, California.

Date	Description	Charges	Balance
(Inclusive dates)	Infected obstetrical ward (adult) twelve days at $4.32	$50.76	
(Date)	Ambulance—To hospital..	2.50	
(Date)	Operative — Salpingectomy and oöphorectomy	64.60	$117.86

["Operative," with names of operations, is used as a synonym for "use of operating room." See also notation in February issue, page 106, third paragraph.]

* * *

(COPY)

Los Angeles, California.
February 23, 1938.

Dear Doctor:

I am deeply puzzled regarding this bill, which has been standing for a couple of years. I cannot see why they keep on hounding me. I have written them at least four or five times referring to the same.

In the first place, Doctor, I did not want to be sent to the hospital, and as soon as my arm was set I begged, daily, to be sent to my home, as I knew that I could not pay the big bill of $103, and my husband who was, and is yet out of employment was quite able to care for me at home. They insisted on keeping me there, at any rate, in the room with eight other patients, who were on the county and being taken care of. I was not, as I had a small house and was renting rooms for a livelihood in order to keep away from the county care.

At first, when I returned to my home and they kept hounding me, I wrote them and said that I would try to make payments as I could, but I have not been able to do so. Each letter that reaches me makes me panicky, and I am truly frightened to death at being sent to prison or having to be punished for not paying.

In the first place, it is a charity hospital, and three or four or more could not pay or even intended to pay, as they, too, knew they could not do so. When I found the bill sent me I was beside myself, and have written them several times regarding same.

May I ask your advice as to what I should do? I simply have not the means, and am trying my best to keep up and not go to anyone for aid.

I shall patiently await your advice or some word from you, as I do not wish to be dragged to court in this mix-up.

Very kindly, I remain

(Name)
(Address)

* * *

(COPY OF DEMAND FOR PAYMENT WHICH WAS ENCLOSED WITH THE LETTER WHICH PRECEDES)

COUNTY OF LOS ANGELES
DEPARTMENT OF CHARITIES

Los Angeles, California,
February 21, 1938.

Address reply to:
Collection Division,
Room 210, Welfare Building,
434 South San Pedro Street.

Re: (name)
Col. File (number)

(Name of above patient)
(Address)

Dear Mrs. (name)

Our last letter to you advised that unless your account was given immediate attention, it would be referred for legal action. Evidently you fail to realize its seriousness, as that letter also has been ignored.

We feel that you should understand your legal liability, so that an amicable settlement can be arranged with this office rather than permitting action by the county attorney.

State law and county ordinance demand action against all persons able to pay, or against their relatives of the degree of spouse, parent, and adult child. The county attorney is required to prosecute such cases to the fullest extent of the law, should it become necessary.

Unless you are fully prepared to defend legal action, we must ask that you communicate with us before February (date). It is our desire to be helpful if you show a spirit of coöperation; otherwise we shall be obliged to follow the above procedure.

Yours very truly,
DEPARTMENT OF CHARITIES
COLLECTION DIVISION
By (name)

* * *

(COPY)

February 10, 1937.

Dear Sir:

No doubt your recent article anent our County Hospital will create hostility among the politicians who usurp the right to control those things purchased with public money and finally, through some quirk of mind peculiar to politicians, come to consider themselves the owners thereof, instead of courteous servants the taxpayers guilelessly expected.

What I have to relate may help your effort to correct abuses that confront poor people who, with faith and gratitude, attempt to avail themselves of the services for which the Hospital was dedicated.

Some eighteen months ago, my wife, suffering from a bad case of prolapsus—a sore having developed on one of the organs, was advised by Dr. (name of physician) to seek treatment at the County Hospital, as we were no longer able to pay for treatment. After a lengthy interview in which we laid bare our previous lives and present condition, against which I do not complain, my wife was admitted and I returned home.

That same evening I was called to come and take her home. I did so, learning that her blood pressure was too high to permit an operation and that she should be treated at the Clinic until her condition was more favorable to correct the cause of her illness. That sounded reasonable. Visits to the Clinic continued for some time, until the pain caused by the pressure, exerted by the prolapsed organs in the pelvic area, became acute, and I had no alternative but to take her back to the hospital. That was on May 1, 1937.

The following day I was told by the attending physician that my wife was a gynecological case, that the bladder had a tendency to tip, backing the urine to the kidneys. The cause being known, I thankfully expected a cure.

To my surprise, my wife was discharged May 17, with no explanation other than that she should resume Clinic treatment. Notwithstanding her weakened condition, these visits were continued, she at first paying 50 cents a treatment, later raised to one dollar per. Later, my wife was advised she was no longer entitled to treatments at the General Hospital and was given a transfer to White Memorial.

By this time, while the sore appeared to have been successfully treated, nothing had been done to rectify the basic cause. Besides, the poor woman had been in suspense for months in fear of cancer, was worn out and despondent. In fact she no longer was in condition to stand the strain of hours of waiting at a clinic. Of course, one realizes that one must take their turn where so many are seeking relief.

Subsequently I received the attached bill for $64, and on interviewing Mr. (name) (a most courteous man) I was informed that a social worker had reported I had two single adult sons who each had earned $70 the month investigated, whereas he had been advised that the combined earnings of the two had been that amount.

My wife has suffered grievously through that error. How much more human it would have been to have given us an opportunity for correction of that mistake, instead of arbitrarily discharging a sick and harassed woman!

From then on, my wife lay on a cot, under a tree, at home, with me as attendant.

She being 69 and I, 68, we applied for the old-age pension last August and, while I am told it is still under investigation, we have been granted temporary assistance, the amount for February being $12.18 for me, $12.17 for my wife. After rent and utilities are deducted there is not much left to subsist for a month on, especially where the housewife is sick. However, we were given medical treatment, Doctor (name of physician) attending.

On December 28, Doctor (name) considered it advisable to commit my wife to the General Hospital. Again I was subjected to a long interview, notwithstanding the previous file must have been available. At this interview I was asked how much money I had on my person at present. I had exactly 20 cents. Imagine our surprise when nine days later—January 7—my wife was again discharged. She was asked if she had a home to go to, and on the answer to the question, why? (knowing she was not well) was told, "This is not a free boarding house." There are witnesses to that remark. Remember, a physician, acting for the county, sent her to the hospital. Of course, his authority ceased with that action.

My wife is now lying at home, unable to be on her feet but briefly. Doctor (name) informs me he has reported her condition. Apparently it is being regarded as just another report. . . .

There really seems no way for the aged and poor to get by unsympathetic officialdom without some influence. It is a travesty on that beautifully carved inscription that appears above the portal that it should be so willfully misinterpreted by officials who assume now to rule our destinies.

It would really seem that the object is to shunt out those unable to pay to make room for paying patients. The reason for this I leave to the conscience of those responsible. This is a long recital, Doctor, and I thank you for the patience that has brought you thus far. I am somewhat in despair myself and can but hope that this will help you in your endeavor to correct the injustices and abuses enacted by those in charge, which seem to be contrary to the ideal that inspired the building of our magnificent hospital.

Yours very respectfully,

(Name)
(Address)

P. S.—I am confiding my name and address to you, Doctor, with the request it not be revealed, unless you deem it necessary, to those in whose power it is to exert reprisals, as, whether you believe it or not, I know that punishment will be meted out by those on whose toes you tread—even to the extent of denying us the present abundant living we are enjoying! My wife and I have been married forty-four years, two sons were in France twenty months helping to win the war to end wars, and I worked over for forty-five years for American corporations—and now this! [Three references were also given.]

FOR THE GOOD OF THE CAUSE—IN RE: LOS ANGELES COUNTY HOSPITAL*

At a recent meeting of the general staff of the Los Angeles County Hospital a question was raised which should receive the further and particular attention of this (Surgical) Section.

When the newly appointed statistician concluded his fantastic dissertation on the novel method of accounting about to be instituted in the auditing department, the chairman of the meeting offered certain pungent comments on regimentation of the profession—to the huge delight of most of those present. It is to this question that I would invite your special attention; rather reluctantly, I confess, because some of the observations which I have long felt should be made and discussed openly may not appeal to the powers that be as "for the good of the cause."

A former superintendent of this hospital once said in my hearing, when he was a little peeved by the chance remark of a staff member: "Any attending man who does not approve of the way things are conducted in this hospital, always has the privilege of resigning. There is an average of more than twenty applications for every possible vacancy." Such a statement from such a source makes me fully aware that I may be about to tread on dangerous ground. I insist, however, that my purpose is not to criticize, but merely to point out certain abuses which could be—and should be—corrected.

I yield to no one in admiration for and loyalty to this great institution. I realize the many difficulties attending its administration, and that red-tape tangles and instances of unintentional injustice are perhaps inevitable. But I share the common opinion that the underlying cause of most of the difficulties and injustices lies in the patent fact that the Hospital is, and always has been, the puppet of politics.

A long list of complaints and abuses might be pointed out, but my purpose here is to discuss only one of the most flagrant which especially concerns the surgical staff. That one is best approached by asking a simple question: Why is the Los Angeles County Hospital?

The law declares that its purpose is to provide medical and surgical care for the *indigent sick* of Los Angeles County. By implication, at least, the purport of the law is that no other class than the indigent sick is to be cared for. Everyone recognizes that, in the nature of things, it is not possible for the Hospital to know the exact economic status of all patients at the time of admittance. But a subsequent check-up is always possible, and is regularly made. When it is found that the Hospital costs can be extracted from a patient, the law permits and the authorities demand that this be done. Do the law and the authorities take a similar view of the value of the medical and surgical services rendered when the patient is found able to pay? *They do not.* On the contrary, even though a wealthy patient is

* Condensation of a paper read before the Surgical Section of the Los Angeles General Hospital staff at the October, 1936, meeting by A. B. Cooke, M. D., a senior attending surgeon of more than twenty years' continuous service.

treated, there is no provision for compensating the doctor. Indeed, the distinct understanding is that no bill for professional services may be rendered, even though the services may have been of a life-saving nature, and notwithstanding that the patient has been found abundantly able to pay, so that no remuneration of any kind may be expected, sought, or accepted if offered. In other words, the medical man is entitled to no consideration: let the Hospital be paid—and to hell with the doctor!

It is a self-evident truth that there would be and could be no such thing as a hospital without the medical profession. Of course, an administration department is necessary; of course, a culinary department is necessary; of course, a nursing department is necessary; and equally, of course, a long and varied list of more humble employees are necessary for the efficient maintenance of miles of expensive corridors and acres of imposing space. And each one of these employees, in every department, expects and receives adequate compensation for his or her services—which is as it should be. It may be mentioned, in passing, that the average number of employees, exclusive of the attending staff, exceeds the average number of patients at all times!

But the medical man, the very heart of the institution, the basic factor which renders its existence possible, not only receives no monetary consideration, but is expected to serve skillfully and faithfully, bearing the major burden of safeguarding human lives, without regard to the justice involved.

We all know that the conditions under which the Hospital operates today are vastly different from those of twenty years ago. Complexities resulting from enormous increase in population and tremendous changes in the hazards of modern life, have brought many new problems to be dealt with. Among these may be cited the great increase in the number of motor vehicles and the resultant multiplied traffic casualties.

As an illustration: a messenger from some outlying apartment house rushes into the corner drug store at midnight in quest of relief for Tom, Dick, or Harry, who is suffering with intense abdominal pain or has been seriously injured in an automobile accident. He is advised to send the patient, not to *a* hospital, but to the General Hospital. When the patient arrives, it is soon evident that immediate surgery is imperative. There is no time to discuss matters of finance: a life is in danger. The operation is performed, the life saved. Afterward, it is ascertained that the patient is a visitor in the city and that he has unlimited means. Does the surgeon receive compensation for his life-saving work at midnight? *He does not, but the hospital is always paid!*

Or an automobile accident on a county highway results in abdominal trauma, with a ruptured viscus and concealed hemorrhage. The patient is probably unconscious. Immediate surgery is necessary—no time to investigate the matter of ability to pay. Later it comes to light that the patient is a wealthy man or woman, or collects substantial liability insurance. Who gets paid? The Hospital *always*—the surgeon *never!*

Again: scarcely a week passes in which the newspapers fail to record that some patient of a prominent family, or of known prosperous business connections, is confined in the General Hospital or has died there. In all such instances the medical man, as usual, is left with the bag to hold. It can hardly be expected to promote his happiness and peace of mind to observe that the patient is provided with one or more special nurses, for whom the requisite funds apparently can always be found.

Boiled down to a few words the point of the foregoing is this: As a matter of ordinary right thinking, *the surgeon who does the life-saving work is entitled to, and should receive compensation in every case in which the Hospital collects payment.* This should be the law on the subject, and should represent the attitude of the governing authorities. The profession does not seek or desire remuneration for services rendered to the *truly indigent.*

The layman whose attention is directed to the facts above set forth, without exception finds himself unable to credit them. "True," says he, "physicians have long been looked upon as 'easy marks,' but surely they are not such *chumps* as that!"

Between regimentation on the one hand and open exploitation on the other, the practice of medicine bids fair soon to become the least inviting of all vocations. Will it be forced to abandon its cherished ideals and traditions? Yes, unless, in self-defense, it arouses to oppose abuses wherever and whenever they are encountered.

What is a *charity* hospital?

2007 Wilshire Boulevard.

MALPRACTICE INSURANCE*

To the Board of Directors of the San Francisco County Medical Society:

Your special committee on malpractice insurance submits this its formal report of the extensive investigation it has conducted with respect to the various physicians' defense and indemnity insurance contracts now available to the members of the San Francisco County Medical Society.

Upon undertaking its work, the committee found that the following insurance companies, authorized to transact the business of liability insurance in the State of California, were issuing physicians' defense and indemnity insurance contracts: The Medical Protective Company of Fort Wayne, Indiana; The United States Fidelity and Guaranty Company; and Zurich General Accident and Liability Insurance Company, Ltd.

The committee also found that a number of surplus line brokers were engaged in writing physicians' defense and indemnity insurance contracts on behalf of different groups of underwriters at Lloyd's in London, England. The committee has been informed by the Society's attorney that surplus line brokers are authorized by the California Insurance Code to issue contracts of insurance in any particular field after it has been determined by the Insurance Commissioner that less than 50 per cent of the authorized and admitted insurers doing the particular class of insurance business involved (in this case liability insurance) are refusing to issue insurance contracts of the type sought to be issued by the surplus line brokers.

With respect to those insurance companies authorized to transact a liability insurance business in the State of California, the committee found the following: The Medical Protective Company of Fort Wayne, Indiana, issues physicians' defense and indemnity policies to members of the California Medical Association only, at the rate of $32 per annum and with a coverage of $5,000 to $15,000, but excludes the following: (*a*) most surgery unless done in an emergency; (*b*) any liability growing out of the ownership, operation, and supervision of any x-ray equipment for therapeutic work; or (*c*) any liability arising out of the ownership, operation, and supervision of any hospital, sanitarium, or clinic, or any business enterprise. Upon payment of a premium of $48 per annum the company will remove the surgery restriction. In other words, a surgeon must pay $48 per year for coverage of $5,000 to $15,000. It appears that the Medical Protective Company will insure against liability arising from the use of x-ray equipment for therapeutic work at a premium of not less than $150 for the minimum coverage.

The United States Fidelity and Guaranty Company issues a physicians' defense and indemnity insurance contract to members of the California Medical Association only with a rider which excepts x-ray treatment and hospital ownership or employment, but does not restrict coverage as to surgery. The committee has been informed from time to time by individuals, physicians, and others, that the rates of the United States Fidelity and Guaranty Company have increased considerably in the past year. The committee understands that the present rates vary from a minimum of $40 per year for $5,000 to $15,000 coverage for general practitioners to a maximum of $92 per year for $50,000 to $150,000 for surgeons and $147.20 per year for a like coverage for x-ray specialists.

The Zurich General Accident and Liability Insurance Company, Ltd., according to the committee's information, will issue physicians' indemnity policies in certain instances, but the committee is also informed that the Zurich will not issue a policy to a physician who is not a member of his county society and the state association, and even

* This is a copy of the report submitted to the San Francisco County Medical Society by its Special Committee on Malpractice. See also February issue, on page 148, for report of the Los Angeles County Medical Association Committee.

though a physician is a member of his state and county societies the company exercises a rigid selection; in other words, the committee is informed that the Zurich is not at all anxious to enter the malpractice field on a large scale. The committee has not had an opportunity (through no fault of the Zurich) to examine its policy forms.

There may be other insurance companies authorized to do business in California which will write malpractice policies, but an exhaustive inquiry by your committee has failed to disclose them. However, there are so many insurance companies operating in this State that it was impossible for the committee to address an inquiry to each.

On the whole, the insurance companies which have just been discussed, their policies and their premium rates, are well known to the medical profession and, consequently, need not be further discussed herein. On the other hand, the large number of surplus line brokers representing various groups of underwriters located at Lloyd's in London, England, who are engaging in the malpractice insurance business in this State, are not so well known to the medical profession nor are their policies or, in fact, the very nature of Lloyd's insurance.

Before discussing malpractice policies issued in the name of Lloyd's of London, it may be advisable to relate briefly the nature and functioning of Lloyd's of London. Lloyd's is divided into many groups of underwriters, each operating independently of the other. In California these groups are represented by approximately thirty-seven agencies known as "surplus line brokers." Insurance agents in the various towns and cities of the State place the insurance of their clients (*i. e.*, physicians) with the surplus line broker. In insurance terminology the insurance agent is known as the "producer," and the surplus line broker is often referred to as the "broker," "underwriter," or "agent." (Mr. Peart advises that this language utterly disregards the legal distinction between an "agent" and a "broker.")

The various Lloyd's groups (often referred to as "underwriters"), each acting for itself, prepare so-called underwriting contracts by the terms of which the particular group authorizes specified agents (surplus line brokers) in various parts of the world to issue contracts of insurance to individuals in the name of "Lloyd's of London." Each member of the underwriting group signs his name to this underlying contract and indicates after his name the proportion of the total liability which may be incurred on all of the insurance contracts ultimately issued which he agrees to be personally responsible for. Copies of this underlying contract are then made available to the agents of the particular underwriting group all over the world. Acting pursuant to the authority contained in an underlying contract, surplus line brokers in California issue and sign malpractice insurance contracts bearing the name "Lloyd's of London."

At this point your committee desires to quote from a letter received by the committee from an insurance agent in San Francisco:

"To begin with, Lloyd's have had little experience with malpractice insurance. If the London market should be opened up generally, it will not be done as a gesture to the professional man. From our own experience we can definitely state that it has been and will be used as an accommodation to the insurance agent to further his volume of business with the surplus line broker, who also represents other carriers writing all forms of insurance. Typical of this point is the letter at hand from one of these agencies and with respect to malpractice insurance, which states in part: 'Following the existing custom, we shall require the placing with our office of correlated lines of insurance such as fire, casualty, etc.' Inevitably the insurance producer, valuable in other lines of insurance and using his volume of other business as an inducement, will place malpractice insurance for his doctor client, regardless of affiliation (as in the past, we can conclude that little thought will be given to membership in medical societies or associations), claims frequency or reputation. In this manner many undesirable risks will be obtained, thereby adversely affecting the experience of the business in general. Likewise, rate competition will enter into the picture. At the present time there is one representative of Lloyd's advertising a malpractice policy for $16 for three years, needless to say a totally unsatisfactory contract. Further than this it is obvious that, should a number of groups write this policy, none of them would have a large premium income. With an annual premium of approximately $30 in the average instance and an isolated loss of $10,000, the carrier would suffer an irreparable loss and would immediately refuse to handle further business. The repercussion of this experience would resound throughout the entire group. With a volume of preferred business concentrated in one group, the same loss could be absorbed. Another complication would be the danger of various groups changing their policy from time to time. In our own case neither the policy form nor rates would ever be changed without notification to attorneys and medical societies. This could not be done with all producers and surplus line brokers, and the result would be an impossible situation wherein attorneys would be called upon to review as many as six thousand policies annually."

From the foregoing it is apparent that the question of placing malpractice insurance with surplus line brokers representing underwriting groups at Lloyd's in London, England, is a serious and immensely complicated problem. In addition to the problems created by the very nature of Lloyd's, there are the legal problems which exist as a consequence of Lloyd's being situated several thousand miles away from the State of California. During its investigation your committee sought the opinion of Mr. Hartley F. Peart, the Society's attorney, and a portion of his exhaustive reply is quoted herein for the careful consideration of all members of the Society.

"*Actions to Enforce the Assured's Rights.*—The most important legal problem with respect to Lloyd's of London malpractice policies, arises from the fact that the Lloyd's underwriters are in England, not in California. If for any reason a physician holding a Lloyd's policy found it necessary to take action against the insurer, such physician would be required to bring suit or present his claim in England. This problem is of extreme importance because insurance protection is no protection at all if the various insured persons are unable to hold the insurer to the terms of its contract except by proceeding in a jurisdiction five or six thousand miles away. Of course, we realize that Lloyd's of London has never failed to meet its obligations—but no one can foretell the future—and even though Lloyd's should not actually refuse to pay claims or judgments, there is always the distinct possibility of a difference of opinion in a particular case with respect to whether or not the terms of the policy cover the injury. Disputes relating to coverage often occur and are inherent in the nature of insurance contracts.

"The draftsman of the policy which has been submitted to us has recognized this point and has made a praiseworthy effort to overcome the disadvantage of tremendous distances. Paragraph 10 reads as follows:

" 'It is agreed that in the event of dispute as to the validity of any claim made by the assured under this policy of insurance, underwriters hereon, at the request of the assured, will submit to the jurisdiction of the courts of the state in which the principal office of the assured is located; and will comply with all legal requirements necessary to give such courts jurisdiction; and that in any suit instituted by the assured against any one of them upon this contract, underwriters herein will abide by the final decision of the courts of such state and settle accordingly.'

"The purpose of the above paragraph is to provide specifically that the underwriters of Lloyd's may in all cases be sued in California, thus obviating, to some extent at least, the difficulty. Paragraph 10 will overcome the problem under discussion *if* it is enforceable. In order to determine whether or not it is enforceable, we have devoted considerable time to an examination of the English law. It is necessary to determine the English law upon this point, because in the last analysis, even though the underwriters are sued in California, in order to collect any judgment in England (assuming, of course, that the underwriters have no property upon which execution can be levied in California).

"The English law appears to be fairly well settled to the effect that a party to a contract may consent in advance to the jurisdiction of a particular court, even though that party is not actually within the territorial limits of the court's process. See *Earl of Halsbury, Laws of England*, Vol. VI, pp. 284-286; *Vallee* vs. *Dumergue* (1849) 4 Exch. 290; *Rousillon* vs. *Rousillon*, 14 Ch. Div. 351; *Copin* vs. *Adamson*, L. R. 9 Exch. 345, 31 Law Times 242; and *Gilbert* vs. *Burnstine*, 73 A. L. R. at 1458.

"In the *Copin* case it was held that an English shareholder in a French company was bound by a clause in the articles of association of the Company by which all disputes between English shareholders were required to be submitted to the French courts and by which every shareholder was required to effect a domicile for the purpose of service of process in France and in default of such acquisition of domicile service was authorized to be made at a certain public office in Paris.

"The above cases go to the question of the validity of a contractual provision such as paragraph 10. In addition, there is a second question, viz.: If a judgment is obtained in California, will the English courts enforce it without re-examining the merits of the case? Early English decisions generally held that while a foreign judgment in a personal

suit was sufficient to give a ground of action and amounted to *prima facie* evidence of debt, yet it was not conclusive and the case might be reëxamined on the merits. It is now settled that a foreign judgment, when rendered by a court having jurisdiction and without fraud and while still remaining in force abroad, is binding and conclusive in the English courts in all cases and not open to impeachment or reëxamination on the merits. See 26 *Harvard Law Review* 298-301; *Harvey* vs. *Farnie*, 8 App. Cas. 43, 5 Eng. Rul. Cases 703; *Castrique* vs. *Imrie*, L. R. 4 H. L. 414, 5 Eng. Rul. Cases 899; and 34 *Corpus Juris* 1167.

"From English decisions we may conclude, first, that a party may by contract consent to the jurisdiction of a foreign court; and, second, that a judgment obtained in a foreign country pursuant to such a consent will be enforced in England. However, there is one point with respect to the English law which must be considered. The cases upholding consent by contract are cases in which some means of serving process was specifically provided in the contract. Paragraph 10 in the policy under consideration does not provide any such means; therefore, it is our opinion that it should be revised to include an agent in California for the purpose of accepting process."

In addition to the problems discussed by Mr. Peart, the committee was advised of the fact that there are at least a dozen and probably many more different types of Lloyd's contracts issued in this State by different surplus line brokers, each representing a particular underwriting group in London. Some of the Lloyd's policies brought to the attention of the committee were wholly inadequate, others afforded a fair degree of coverage, and a few compared favorably with policies issued by domestic insurers. But all of these policies presented the problem of enforcement in England and the additional problem of financial reserves in California.

Finally, one broker, the Lloyd M. Kahn Company of San Francisco, submitted a policy form to the committee for its approval or disapproval. This form was submitted to Mr. Peart with the request that he review it and suggest any changes that, in his opinion, would benefit the medical profession. Mr. Peart reviewed the policy and submitted a written opinion in which several changes were strongly recommended, including a paragraph by which the surplus line broker acting for the underwriting group at Lloyd's would consent to the jurisdiction of the California courts and a paragraph by which the underwriters would appoint an agent in San Francisco to act for them in all matters arising under the policy. All of these recommendations were immediately accepted by the Lloyd M. Kahn Company, and your committee was subsequently informed by Mr. Lloyd M. Kahn that the underwriting group at Lloyd's in London, upon whose behalf he was acting through a surplus line broker in San Francisco, had likewise accepted all of the recommendations. Thereupon your committee expressed its approval of this particular policy and caused such approval to be published in the Bulletin of the Society.

Only one other surplus line broker or agent representing underwriters at Lloyd's has submitted to your committee any form for approval or disapproval, and, unfortunately, that policy (submitted by O'Brien and Blackman Company) has not as yet been received from the Society's attorney, to whom it was recently referred by the Board of Directors.

Therefore, and taking into account the admittedly chaotic condition which exists with respect to Lloyd's of London malpractice insurance, your committee expressly recommends that the San Francisco County Medical Society express for the time being its lack of approval of all malpractice insurance policies issued in the name of Lloyd's of London, except the particular policy form issued by the Lloyd M. Kahn Company and previously approved, as stated above.

Before concluding, your committee once again desires to recommend to the members of the San Francisco County Medical Society that each and every member obtain membership in the Medical Society of the State of California. Membership in the Medical Society is obtainable upon application by any physician who is a member of the California Medical Association and who carries at least $5,000 of malpractice insurance. Membership cost is nominal, and it means that competent expert legal assistance can be obtained by the member to guard his personal interests and to aid his insurer's attorney if he is sued or threatened with suit. Your committee specifically recommends that every member of the County Society communicate with Dr. F. C. Warnshuis, Secretary of the Medical Society of the State of California, for further details.

The committee approves the three old line companies—Fort Wayne, United States Fidelity and Guaranty, and the Zurich—and of the Lloyd's policies studied by the committee, the committee believes the policy issued by the Lloyd M. Kahn Company to be the best available at the present time.

Respectfully submitted,

P. K. Gilman, *Chairman.*

January 10, 1938.

THE PHYSICIAN'S INCOME TAX—1938*

This discussion relates only to the requirements of the Federal income tax law. Information with respect to the requirements of state income tax laws should be obtained from responsible state sources.

The Revenue Act of 1936 amended in numerous respects the prior income tax law, but none of the changes made relate to physicians as a class distinct from the main body of federal income taxpayers.

Every one who is required to make a Federal income tax return must do so on or before March 15, unless an extension of time for filing his return has been granted. For cause shown, the collector of internal revenue for the district in which the taxpayer files his return may grant such an extension, on application filed with him by the taxpayer. This application must state fully the causes for the delay. Failure to make a return may subject the taxpayer to a penalty of 25 per cent of the amount of the tax due.

The normal rate of tax on residents of the United States and on all citizens of the United States regardless of their places of residence is 4 per cent on net income in excess of the exemptions and credits.

WHO MUST FILE RETURNS

1. If gross income was less than $5,000 during 1937, a return must be filed (*a*) by every unmarried person, and by every married person not living with her husband or his wife, whose net income was $1,000 or more, and (*b*) by every married person living with her husband or his wife, whose net income was $2,500 or more. If the aggregate net income of husband and wife, living together, was $2,500 or more, each may make a return or the two may unite in a joint return.

2. Returns must be filed by every person whose gross income in 1937 was $5,000 or more, regardless of the amount of his net income and of his marital status. If the aggregate gross income of husband and wife, living together, was $5,000 or more, they must file either a joint return or separate returns, regardless of the amounts of their joint or individual net incomes.

If the status of a taxpayer, so far as it affects the personal exemption or credit for dependents, changed during the year, the personal exemption and credit must be apportioned, under rules and regulations prescribed by the Commissioner of Internal Revenue with the approval of the Secretary of the Treasury, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month should be disregarded unless it amounts to more than half a month, in which case it is to be considered as a month.

As a matter of courtesy only, blanks for returns are sent to taxpayers by the collectors of internal revenue, without request. Failure to receive a blank does not excuse any one from making a return; the taxpayer should obtain the necessary blank from the local collector of internal revenue.

The following discussion covers only matters relating specifically to physicians. Full information concerning questions of general interest may be obtained from the official return blank and from the collectors of internal revenue.

GROSS AND NET INCOMES: WHAT THEY ARE

Gross Income.—A physician's gross income is the total amount of money received by him during the year for pro-

* Prepared by the American Medical Association Bureau of Legal Medicine and Legislation. From the *Journal of the American Medical Association*, January 20, 1938.

fessional services, regardless of the time when the services were rendered for which the money was paid, plus such money as he has received as profits from investments and speculation and as compensation and profits from other sources.

Net Income.—Certain professional expenses and the expenses of carrying on any enterprise in which the physician may be engaged for gain may be subtracted as "deductions" from the gross income, to determine the net income on which the tax is to be paid. An "exemption" is allowed, the amount depending on the taxpayer's marital status during the tax year as stated before. These matters are fully covered in the instructions on the tax return blanks.

Earned Income.—In computing the normal tax, but not the surtax, there may be subtracted from net income from all sources an amount equal to 10 per cent of the earned net income, except that the amount so subtracted shall in no case exceed 10 per cent of the net income from all sources. Earned income means professional fees, salaries, and wages received as compensation for personal services, as distinguished from receipts from other sources.

The first $3,000 of a physician's net income from all sources may be regarded under the law as earned net income, whether it was or was not in fact earned within the meaning set forth in the preceding paragraph. Net income in excess of $3,000 may not be claimed as earned unless it in fact comes within that category. No physician may claim as earned net income any income in excess of $14,000.

DEDUCTIONS FOR PROFESSIONAL EXPENSES

A physician is entitled to deduct all current expenses necessary in carrying on his practice. The taxpayer should make no claim for the deduction of expenses unless he is prepared to prove the expenditure by competent evidence. So far as practicable, accurate itemized records should be kept of expenses and substantiating evidence should be carefully preserved. The following statement shows what such deductible expenses are and how they are to be computed:

Office Rent.—Office rent is deductible. If a physician rents an office for professional purposes alone, the entire rent may be deducted. If he rents a building or apartment for use as a residence as well as for office purposes, he may deduct a part of the rental fairly proportionate to the amount of space used for professional purposes. If the physician occasionally sees a patient in his dwelling house or apartment, he may not, however, deduct any part of the rent of such house or apartment as professional expense; to entitle him to such a deduction he must have an office there, with regular office hours. If a physician owns the building in which his office is located, he cannot charge himself with "rent" and deduct the amount so charged.

Office Maintenance.—Expenditures for office maintenance, as for heating, lighting, telephone service and the services of attendants, are deductible.

Supplies.—Payments for supplies for professional use are deductible. Supplies may be fairly described as articles consumed in the using; for instance, dressings, clinical thermometers, drugs and chemicals. Professional journals may be classified as supplies, and the subscription price deducted. Amounts currently expended for books, furniture and professional instruments and equipment, "the useful life of which is short," generally less than one year, may be deducted; but if such articles have a more or less permanent value, their purchase price is a capital expenditure and is not deductible.

Equipment.—Equipment comprises property of a more or less permanent nature. It may ultimately wear out, deteriorate or become obsolete, but it is not in the ordinary sense of the word "consumed in the using."

The cost of equipment, such as is described above, for professional use, cannot be deducted as expense in the year acquired. Examples of this class of property are automobiles, office furniture, medical, surgical, and laboratory equipment of more or less permanent nature, and instruments and appliances constituting a part of the physician's professional outfit, to be used over a considerable period of time, generally over one year. Books of more or less permanent nature are regarded as equipment and the purchase price is, therefore, not deductible.

Although the cost of such equipment is not deductible in the year acquired, nevertheless it may be recovered through depreciation deductions taken year by year over its useful life, as described below.

No hard and fast rule can be laid down as to what part of the cost of equipment is deductible each year as depreciation. The amount depends to some extent on the nature of the property and on the extent and character of its use. The length of its useful life should be the primary consideration. The most that can be done is to suggest certain average or normal rates of depreciation for each of several classes of articles and to leave to the taxpayer the modification of the suggested rates as the circumstances of his particular case may dictate. As fair, normal or average rates of depreciation, the following have been suggested: automobiles, 25 per cent a year; ordinary medical libraries, x-ray equipment, physical therapy equipment, electrical sterilizers, surgical instruments and diagnostic apparatus, 10 per cent a year; office furniture, 5 per cent a year.

The principle governing the determination of all rates of depreciation is that the total amount claimed by the taxpayer as depreciation during the life of the article, plus the salvage value of the article at the end of its useful life, shall not be greater than its purchase price or, if purchased before March, 1913, either its fair market value as of that date or its original cost, whichever may be greater. The physician must in good faith use his best judgment and claim only such allowance for depreciation as the facts justify. The estimate of useful life, on which the rate of depreciation is based, should be carefully considered in his individual case.

In a Treasury Decision, approved February 28, 1934, No. 4422, it is held, among other things, that

1. The cost to be recovered shall be charged off over the useful life of the property.

2. The reasonableness of any claim for depreciation shall be determined on the conditions known to exist at the end of the period for which the return was made.

3. Where the cost or other basis of the property has been recovered through depreciation or other allowances, no further deduction for depreciation shall be allowed.

4. The burden of proof will rest on the taxpayer to sustain the deduction claimed.

5. The deduction for depreciation in respect to any depreciable property for any taxable year shall be limited to such ratable amount as may reasonably be considered necessary to recover during the remaining life of the property the unrecovered cost or other basis.

Particular attention is called to the last of the foregoing provisions. If, in prior years, rates have been claimed which, if continued, will fully depreciate the cost, less salvage, before the end of its useful life, based on conditions now known, a reëstimate of the remaining useful life should now be made and the portion of the cost that had not been depreciated at the beginning of the year 1937 (for a return for the year 1937) should be spread over this reestimated life.

Medical Dues.—Dues paid to societies of a strictly professional character are deductible. Dues paid to social organizations, even though their membership is limited to physicians, are personal expenses and not deductible.

Postgraduate Study. — The Commissioner of Internal Revenue holds that the expense of postgraduate study is not deductible.

Traveling Expenses. — Traveling expenses, including amounts paid for transportation, meals and lodging, necessarily incurred in professional visits to patients and in attending medical meetings for a professional purpose, are deductible.

Automobiles.—Payment for an automobile is a payment for permanent equipment and is not deductible. The cost of operation and repair, and loss through depreciation, are deductible. The cost of operation and repair includes the cost of gasoline, oil, tires, insurance, repairs, garage rental (when the garage is not owned by the physician), chauffeurs' wages, and the like.

Deductible loss through depreciation of an automobile is the actual diminution in value resulting from obsolescence and use and from accidental injury against which the physician is not insured. If depreciation is computed on the basis of the average loss during a series of years, the series must extend over the entire estimated life of the car, not merely over the period in which the car is in the possession of the present taxpayer.

If an automobile is used for professional and also for personal purposes—as when used by the physician partly for recreation, or so used by his family—only so much of the expense as arises out of the use for professional purposes may be deducted. A physician doing an exclusive office practice and using his car merely to go to and from his office cannot deduct depreciation or operating expenses; he is regarded as using his car for his personal convenience and not as a means of gaining a livelihood.

What has been said in respect to automobiles applies with equal force to horses and vehicles and the equipment incident to their use.

MISCELLANEOUS

Contributions to Charitable Organizations. — For detailed information with respect to the deductibility of charitable contributions generally, physicians should consult the official return blank or obtain information from the collectors of internal revenue or from other reliable sources. A physician may not, however, deduct as a charitable contribution the value of services rendered an organization operated for charitable purposes.

Laboratory Expenses. — The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when under corresponding circumstances they would be deductible if they related to a physician's office.

Losses by Fire or Other Causes.—Loss of and damage to a physician's equipment by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of repair claimed as a deduction.

Insurance Premiums. — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

Expense in Defending Malpractice Suits.—Expense incurred in the defense of a suit for malpractice is deductible as a business expense.

Sale of Spectacles.—Oculists who furnish spectacles, etc., may charge as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should in such cases show charges for services separate and apart from charges for spectacles, etc.

CALIFORNIA CLINICAL LABORATORY LAW AND CHIROPRACTORS*

San Francisco, January 13, 1938.

C. C. Hunt, D.C.,
Secretary, Board of Chiropractic Examiners,
404 Forum Building,
Sacramento, California.

Dear Sir:

In your communication of December 23, 1937, you refer to Chapter 804, Statutes 1937, being "an Act relating to the conduct of clinical laboratories and the licensing of clinical laboratory technologists and clinical laboratory technicians for the purpose of protecting public health," etc. You refer to the printed copy of a communication entitled, "Information Concerning the New Laboratory Law," and recite certain statements which you state to be contained therein.

The first statement is as follows:

> A clinical laboratory is defined to be a place or establishment where any tests, no matter how limited, are made.

This statement is in conflict with Section 2 of Chapter 804, which reads as follows:

> For the purpose of this Act a clinical laboratory is defined as follows: Any place, establishment or institution organized and operated for the practical application of one or more of the fundamental sciences by the use of specialized apparatus, equipment, and methods for the purpose of obtaining scientific data which may be used as an aid to ascertain the presence, progress, and source of disease.

Consequently, the information or statements in the work referred to by you are erroneous.

Section 3 of the Act referred to defines technologist as being "any person who engages in the work and direction of a clinical laboratory as herein defined." Therefore, resort must be taken to Section 2 of the Act defining a clinical laboratory, and the second statement which you state is contained in the document referred to by you is, likewise, erroneous for the reason that it is too broad. There may be many kinds of laboratories which are not covered by the definition of clinical laboratory set forth in the Act.

The expression "technician" is defined in Section 4 of the chapter under discussion, and the information contained in the document referred to by you is incorrect in so far as it conflicts with the definition of technician contained in the Act.

The fourth statement contained in the work referred to by you is correct, provided the technologist is licensed.

You state the applicant for a license under this act, either with or without examination, must have experience and educational qualifications far in excess of those required for license under the Chiropractic Act, and refer to paragraph 12 of the information concerning the new laboratory law, and quote as follows:

> The law does not require technicians working in a doctor's office to be licensed, unless work is done for other doctors, or for the patients of other doctors.

The statement immediately above quoted is correct under the law in so far as it relates to technicians employed in a physician's and surgeon's office who do work for other physicians or the patients of other physicians, said work not being under the immediate control and supervision of his employer. The test is, does the technician do work for his immediate physician and surgeon employer, or does he do work indiscriminately for other physicians and surgeons or for patients of other physicians and surgeons.

The quoted statement is erroneous in so far as it purports to require technicians working in a licensed physician's and surgeon's office to be licensed, if it be construed to require a technician to be licensed if his physician and surgeon employer does work for other doctors or for the patients of other doctors.

The test under the law itself is whether a physician's and surgeon's office is organized and operated as a place for the practical application of one or more of the fundamental sciences by the use of specialized apparatus, equipment, and methods for the purpose of obtaining scientific data which may be used as an aid to ascertain the presence, progress or source of disease. The offices of many physicians and surgeons are not in the nature of things necessarily organized and operated for the purposes hereinabove specifically enumerated. Furthermore, the fact that such physicians and surgeons might "do work" for other doctors or for patients of other doctors does not necessarily make the office of such physician and surgeon a clinical laboratory within the definition thereof contained in the Act.

You quote Section 5 of the Chiropractic Act, which requires one hundred hours of study in chemistry and toxicology and four hundred hours in diagnosis or analysis. You then refer to Section 7 of the Chiropractic Act, and quote that portion thereof relating to the issuance of a chiropractic license, particularly that said "license shall authorize the holder thereof to practice chiropractic in the State of California as taught in chiropractic schools or colleges." The above-quoted provision has been interpreted in the case of *In re Hartman*, 10 Cal. App. (2d) 213, as authorizing the holder of a chiropractic license to practice chiropractic—whatever chiropractic may be—regardless of what the individual was taught in a chiropractic school or college. To the same effect is the opinion rendered by Honorable John J. Van Nostrand, in the Superior Court of the State of California, in that case numbered 257362,

* See letter in this issue from Dr. C. B. Pinkham, on page 214.

and entitled "In re the matter of the application of H. James McGranaghan for Declaratory Relief."

Your primary question is whether a licensed chiropractor must hold an additional license as a technologist and a technician pursuant to the provision of Chapter 804, Statutes of 1937, in order that he may make chemical tests from specimens of his own private patients in his own private office for his exclusive use in arriving at a proper diagnosis of the physical condition of his patient.

In reply, permit me to state that neither a technologist nor a technician, nor a chiropractor, is permitted under the law to make chemical tests from specimens of anyone in order to make diagnoses of the physical condition of a patient for the purpose of preventing the development of progressive malphysical conditions or alleviating or treating diseases or injuries. In our opinion dated January 26, 1926, addressed to your predecessor, Dr. James Compton, this office indicated that measures used by chiropractic licensees had to be founded upon the theory of chiropractic. According to the controlling cases decided since the rendition of such opinion, the making of a chemical test upon humans is within the purview of the practice of medicine, which is specifically prohibited to chiropractors under the provisions of Section 7 of the Chiropractic Act not quoted by you. Those provisions are to the effect that a license to practice chiropractic "shall not authorize the practice of medicine, surgery, osteopathy, dentistry, or optometry, nor the use of any drug or medicine now or hereafter included in materia medica."

In conclusion, may I point out that while persons who can qualify as technologists or technicians may examine specimens to ascertain the existence or nonexistence of certain germs, virus, bacteria or the like, they may not, as above indicated, go so far as to make a diagnosis of the physical condition of the patient without violating the provisions of the Medical Practice Act. This was particularly held in the case of *People* vs. *Jordan*, 172 Cal. 391, where the Supreme Court stated:

> Diagnosis is as much a part of the practice of medicine as is the administration of remedies, and it is a vastly more important branch thereof because, generally speaking, the treatment of disease is governed by the practitioner's theory regarding its cause. . . . To diagnose a case is as much a part of the practice of medicine as the drawing of pleadings and the giving of advice are parts of the practice of law. . . . It is impossible to disassociate diagnosis from the practice of the art of healing by any physical, medical, mechanical, hygienic or surgical means. It is, therefore, competent for the legislature to permit only those persons who are proficient who have been found to be educated up to certain standards to diagnose "ailments."

Very truly yours,
U. S. Webb, *Attorney-General.*
By Lionel Browne, *Deputy.*

GENERAL MEETING PROGRAMS: A PLAN FOR LARGER COUNTY MEDICAL SOCIETIES

"The Bulletin" of the Los Angeles County Medical Association, in the issue of February 17, 1938, printed the following, on the subject of General Meeting Programs. The plan outlined may have suggestive value to county societies having headquarters in the larger cities:

"Members of the Los Angeles County Medical Association are aware that, in recent years, the fifteen scientific sections and the twelve geographical branches of the Society have taken on increased growth and activity; so much so, that the general meetings of the Association not infrequently have had fewer members in attendance than could be counted at section or branch gatherings.

"This splendid development of the sections and branches should go forward, but on the other hand, the good of the whole should not be lost sight of, in the growth of the parts.

"To promote more interest in the general meetings, the Committee on Scientific Work and Programs, with the approval of the Board of Trustees and Council, proposes during the present year to change the character of the general meeting programs, in the hope of securing a larger attendance and interest. It is concerning these innovations that this letter is written.

"The plan, in short, comprehends brief but to-the-point papers on topics of interest to physicians in general practice, dealing with phases of scientific and organized medicine. In addition, it is planned to have a buffet supper (no charge) at the end of each meeting.

"Here are more of the details:

"Each regular, general meeting, to be held on the first Thursday of each month, will have a program presented by three speakers from one of the scientific sections, each essayist presenting a paper or talk that will not take longer than fifteen minutes to deliver (essayists' papers may be of any length, but in his presentation, each speaker will take only fifteen minutes for presentation of its 'high-points.')

"Each of the three topics will be on specialty problems in which men in general practice have an interest. This plan will permit a diversified presentation of three papers in forty-five minutes, with opportunity for discussion in another forty-five minutes (each essayist being requested to send, in advance, carbons of his paper to two friends, who will lead in the discussion).

"In addition, a fifteen minute discussion of some pertinent topic on organized medicine will be given, on subjects such as: County Hospital Problems, Basic Science Act; Anti-Vivisection Initiative; Malpractice Defense.

"Following the completion of the above program, an informal buffet supper will be served at the expense of the Association. Members can go to the table, help themselves to sandwiches and coffee and then move from one group of friends to the other for a half hour or so, and thus promote the friendly and fraternal relationships so necessary in modern day medical societies. Years ago, such buffet suppers were a regular feature of the Association's gatherings and added much to their value.

"Meetings will start promptly at eight o'clock, and the programs be concluded by ten o'clock or before, depending upon the amount of discussion. As to the good fellowship, it to continue as long as the spirit and sandwiches and coffee hold out.

"Also, and by no means the least important, in the months of March, April, and May, special general meetings will be called for the third Thursday evenings, at which the Los Angeles County Medical Association will be host, in turn, to the County Bar, the County Dental and the County Pharmaceutical associations. At these sessions, programs of mutual interest will be given, with talks by members of the professions represented. Of all this however, more later.

"Mention may also be made of a plan that the Committee on Scientific Work and Programs has in mind, to have some well known eastern colleagues, who will have been in attendance at the American Medical Association meeting in San Francisco (June 13-17), to join in presenting a seminar on Saturday morning and afternoon (June 18). If that plan materializes, in due time, special announcement will be made.

"In the meantime, the Association officers ask members to keep in mind the proposed programs, and to give generous aid, through coöperation in attendance and taking part in the meetings."

Before the full force of public health can be realized, we must face the obstacles squarely and resolve to deal with them intelligently. Some of the major obstacles are:

(*a*) Public ignorance and indifference.
(*b*) Lack of sufficient financial support.
(*c*) Political interference.
(*d*) Lack of technically trained and experienced personnel.
(*e*) The stigma associated with certain diseases.
(*f*) Lack of basic public health knowledge on which to build administrative control measures.

It is not necessarily intended that all the items in the foregoing list of obstacles are arranged in the order of their importance, but certainly the last mentioned is the least important, and the first on the list is the most important. When this one is adequately disposed of, (*b*), (*c*), (*d*), and (*e*) will readily cease to be serious problems. Volumes could be written about each one of these obstacles, but in general their handicapping influences are readily understood and self-explanatory.—The Health Officer.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 3, March, 1913

From some Editorial Notes:

Important Suit Won.—On January 28 a most important suit against a member of the Society, Dr. C. A. Shepard, was begun in Los Angeles and lasted over a period of seven days' trial, resulting in a verdict for Doctor Shepard. The suit was for $50,000, and it was alleged that he had fraudulently or untruthfully diagnosed a case of tuberculosis when in truth the patient did not have tuberculosis. . . . Doctor Shepard writes: "I am proud to belong to a State Society that takes such good care of its members in such blackmail cases. The able defense put up by Mr. H. T. Morrow, the attorney for the Society, and the indefatigable efforts of the Secretary of the Los Angeles County Association, Dr. George H. Kress, with the willing assistance of the members of the Society who left their offices and patients to testify on my behalf, is certainly very gratifying." Is it better to keep your dues paid up and get this sort of defense, or to let them lapse and depend on the chances of an "insurance" company's defense?

* * *

Chinese Medicine.—The Pacific Coast members of the medical profession have had very definite notions concerning the absurdities of so-called Chinese medicine. Elsewhere in this issue is printed an article on the subject by a medical missionary, Dr. C. R. Roys of Wei-hsien, China, who discusses the subject from a wide and first-hand knowledge. His paper on the subject is, therefore, of real value. Not the least of what Doctor Roys states is the point which he makes, judging from the newspaper advertisements and sign-board publicity of American patent medicines akin to those of the Chinese, that we of our own land are, after all, not so greatly superior to the heathen (?), upon whom we would look down with such scorn and pity.

* * *

Medical Bills in the Legislature.—In discussing the various bills which have been introduced in the present legislature, and they are more numerous and more dangerous than at any previous session of the legislature in the history of the State, a few fundamental facts must be remembered.

A license to practice medicine or any mode of treating the sick or afflicted is not a piece of property given to an individual; it is a police license intended for the protection of the people and not for the benefit of the person to whom it is issued.

All such licenses, wherever issued, had their origin in the fact that uneducated and unqualified persons were desirous of making money out of sick people.

As it became harder for uneducated persons to obtain license to practice medicine, other systems or modes of treating the sick or afflicted were "discovered," and the followers of these systems asked for special licensing boards in their special systems, claiming that, as they did not wish to practice "medicine," but merely their special "mode," they should not be required to take the regular examination. But it was quite evident that, as a matter of fact, no matter what they said they *wanted* to practice, they all *actually practiced medicine;* or at least they all treated sick or afflicted persons in whatsoever way they saw fit.

The fundamental point of all laws regulating the requirements for a license for anyone to treat the sick or afflicted, is this:

Before being allowed by the State to treat a sick or afflicted person, the individual should be required to prove that he knows how the body is made (anatomy), how it is supposed to perform its functions (physiology), and what accidents or material afflictions are liable to occur to it.

Senate Bill 510, Gates (same as A. B. 425, Ambrose), is a type of bills lowering standards. It provides for three boards of examiners: "a board of medical examiners, a

(Continued in Front Advertising Section, Page 13)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

Board Proceedings

Governor Merriam has announced the reappointment of Doctors Clark L. Abbott of Oakland, Percival Dolman of San Francisco, and George Thomason of Los Angeles, as members of the Board of Medical Examiners for terms ending January 15, 1942. Dr. John MacLean of Los Angeles was appointed to fill the unexpired term of Dr. Harry V. Brown, deceased, ending January 15, 1939.

News

"Governor Frank F. Merriam last night reappointed Doctors Howard Morrow and William P. Clark, both of San Francisco, as members of the State Department of Public Health." (Sacramento *Bee,* January 28, 1938.)

"Attorney-General U. S. Webb today told C. O. Hunt, Secretary of the Board of Chiropractic Examiners, that a chiropractor may not make chemical tests on a human being. Hunt asked the Attorney-General whether the law requiring licensing of laboratory technicians also required a chiropractor to have a laboratory technician's license if he wished to make chemical tests for his own patients. Webb replied by calling attention to the California law forbidding chiropractors to diagnose. He said chemical tests for patients for the purpose of making a diagnosis would constitute medical practice, and that also is forbidden by law in California." (Associated Press dispatch, dated San Francisco, January 14, and printed in the San Jose *Mercury-Herald,* January 15, 1938.)

"Charges against three Los Angeles doctors whose conviction of participating in a state-wide illegal operations ring was reversed, were dismissed yesterday by Superior Judge Arthur Crum on motion of Deputy District Attorney Vernon Ferguson. The three doctors—Valentine St. John, James Beggs, and Jesse C. Ross—were convicted with eight other persons on charges of conspiracy to perform illegal operations. The State Supreme Court held, however, that corroborative evidence against the doctors was insufficient. Among the others convicted are R. L. Rankin, President of the Medical Acceptance Corporation, now in San Quentin Penitentiary; William Byrne, former State Medical Board investigator, who has applied for probation; and Dr. George E. Watts, who died in San Quentin last year." (Los Angeles *Daily News,* January 29, 1938.)

"A new trial was today denied Dr. G. O. McKeehan, Huntington Park physician, who was recently convicted on one count of conspiracy to defraud an insurance company and one count of grand theft in connection with an asserted 'fake accident' ring. In denying the new trial, Superior Judge Frank M. Smith set February 10 as the date for hearing a probation plea and pronouncing sentence. In his trial the prosecution accused him of treating Thomas G. Nelson, assertedly a member of the ring, for injuries inflicted on Nelson by other members of the 'fake accident' group in a plot to collect insurance benefits." (Los Angeles *Herald and Express,* January 28, 1938.)

"With the case attracting the attention of more than 3,500 associates in the chiropractic business in California, the trial of Dr. L. E. Dollarhide, Long Beach chiropractor, in the Riverside justice court here on March 2, is expected to apply an important test to the California laws governing chiropractors. The Long Beach man, who has patients in Riverside and several other towns of the county, recently was arrested on a warrant charging that he illegally

(Continued in Front Advertising Section, Page 19)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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(Continued from Page 30)

and manner of recording essential tests. For example, the Snellen test card for determining visual acuity, Ishihara book or colored disks for detecting color blindness, simple methods for detecting gross defects in field, and cover tests to determine binocular single vision or the more conspicuous muscle abnormalities.

(*b*) When applicants are discovered with defects of vision which fall below the standards set for an unlimited license, such applicants shall be referred to an eye physician for correction of any possible defects. (The major portion of such defects are correctable.)

(*c*) The eye physician shall furnish the applicant or bureau with a written statement of best results obtained by correction of any defects uncorrectable and a recommendation of the fitness or unfitness of the applicant.

6. *Minimum Visual Standards for Licensure: For an unlimited license, provided that physical, mental and aptitude tests are satisfactory, an applicant shall meet the following minimum visual standards:*

(*a*) Visual acuity with or without glasses of 20/40 Sn. in one eye and 20/100 Sn. in the other.

(*b*) A form field of not less than 45 degrees to both sides laterally from point of fixation.

(*c*) Binocular single vision.

(*d*) Ability to distinguish red, green, and yellow.

Glasses, when required, must be worn while driving, and those employed in public transportation shall carry an extra pair.

7. *Visual Standards for Limited License: A limited or restricted license may be issued to applicants who are unable to meet the visual standards set for unlimited license.* The minimum requirements for this shall be:

(*a*) Visual acuity shall be not less than 20/65 Sn. in the better eye. (The one eyed, the aphakic and the color blind are not disqualified.)

(*b*) Field of vision shall be not less than 125 degrees horizontally in one eye.

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CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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(*c*) Diplopia shall not be present.

(*d*) Other personal qualities which may compensate for minor defects of vision and which are necessary for efficient operation of a motor vehicle should rate high for those to whom a limited license is issued. For example, experience, nervous stability, coördination of eye, mind and muscle; and aptitude must be fully adequate to meet the practical road tests.

8. *Renewals, Retesting and Reëxaminations: Physical condition, general, mental, nervous, and ocular, is liable to change, and hence the need for some practical method to discover any acquired incapacity.* The following is suggested:

(*a*) Renewals of license shall be issued at least every third year. The applicant shall with each renewal make a declaration that he knows of no physical,

(Continued on Page 38)

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

I. CLEANSING OPERATIONS

● As reference to a recent text on canning will disclose (1) the details of commercial canning procedures will vary from product to product. There are, however, certain basic operations which are included in practically all canning procedures. In the belief that they may prove of interest, it is our intention to describe in broad detail the nature and purposes of these essential operations.

One of the first and most important steps in commercial canning is the thorough cleansing of the raw food material received at the cannery. The purpose of such an operation is, of course, immediately evident, namely, to remove soil, dirt or other inedible substances which may be present. However, cleaning also serves to reduce substantially the load of spoilage bacteria with which Nature usually endows raw foods.

Commercially, cleansing is effected in a variety of ways. In general, however, water washers specifically designed for the various types of products are used. In these machines, the raw food material is subjected to high-pressure sprays or strong flowing streams of potable water while passing along a moving belt or while being tumbled by agitating or revolving screens. Sometimes a "flotation" type of washer is also used to remove chaff or similar material. With certain products, water washing is preceded by a "dry" cleaning treatment in which adhering soil and dirt is mechanically removed from the food by revolving or agitating screens, or by strong air-blasts.

Also, in certain canning procedures, operations whose basic functions are not primarily to clean the raw material may also exert a cleansing effect. Thus, the "blanch" or scalding treatment accorded many products serves to clean the food, as does the water spray sometimes applied to foods after the blanch.

Modern canners know the necessity of thorough cleansing of the raw materials they use. They appreciate that thorough cleaning and removal of extraneous material decreases the load of spoilage organisms which must be destroyed by the heat processes to which all canned foods are subjected. They also appreciate the necessity of maintaining strict plant and equipment sanitation to destroy spoilage bacteria which may be carried in by raw foods.

Because of the efficient cleansing of raw materials and close attention to the other important operations in the commercial canning procedures, modern canned foods must be ranked among the most wholesome foods coming to the American table. (2)

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) 1937 Appertizing or The Art of Canning, A. W. Bitting, The Trade Pressroom, San Francisco.

(2) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century Co., New York.

This is the thirty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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All Owl Stores have modern and fully equipped pharmaceutical departments.

(Continued from Page 35)

mental or visual defect which has developed during the past year.

(*b*) If any such defects have developed, an examination by a physician and the report thereof shall be required before the license is reissued.

(*c*) When the applicant for renewal of license has a record of repeated accidents, such applicant shall be required to obtain a report from experts duly qualified to determine the probable cause for such accidents before the renewal is issued. Physical fitness (including ocular), psychologic status and general aptitude shall be reconsidered and license granted only on convincing evidence of ability to operate a motor vehicle efficiently.

The Prevalence of Smallpox in the United States and Canada During 1936.—Following a serious setback in 1935, the year 1936 saw practically no improvement in the smallpox situation in the United States. The cases reported by forty-seven states and the District of Columbia totaled 7,813, or close to the 7,904 in these states in 1935. In spite of our vaunted leadership in the control of preventable diseases, there are still large sections of the country where the presence of this loathsome disease is taken as a matter of course. As a result, the United States continues to bear the disgrace of tolerating one of the highest smallpox rates in the civilized world. During seventeen years, 1920 to 1936, more than 650,000 cases of smallpox were reported—a number almost as large as the population of Pittsburgh or of San Francisco.

During 1936, as in previous years, smallpox was most prevalent in the North Central States, the Mountain States, and on the Pacific Coast. There were comparatively few cases in the states bordering the Atlantic Ocean and in the southeastern section of the country. In proportion to its population, the highest incidence of smallpox occurred, last year, in Montana. Here the cases numbered 762 in a population of only 531,000. Close in line was South Dakota with 705 cases in a population of 692,000, while Wyoming, with a population of less than 235,000, registered 202 cases. Other states with outstandingly bad smallpox records in 1936 were Iowa, Kansas, and Nebraska, each of which reported more than seven hundred cases during that year. In other words, six states which contained less than 6 per cent of our entire population registered nearly 51 per cent of the total number of smallpox cases reported last year.

In contrast with the above, it is reassuring to compare the records of the following states: Rhode Island, where there has not been a case of smallpox since 1927; Delaware and Maryland, each of which has reported only one case since 1929; New Jersey, which has been entirely free from the disease since 1931; and Maine and New Hampshire with only two cases each since 1929 and 1931, respectively. Neither Massachusetts nor Pennsylvania has reported a case of smallpox in four years. The District of Columbia has reported only one case in the past eight years.

Fortunately, the disease continues to be of a mild character. Among the 7,813 cases reported in 1936, there were only thirty-three deaths, corresponding to a case-fatality rate of 0.42 per cent. That is to say, there was only one death in every 237 cases. In Canada, on the other hand, the disease seems to have been more fatal, since there were four deaths among only sixty-two cases. Assuming that there was no deficiency in reporting, this is equal to a case-fatality rate of 6.45 per cent, or one death in every sixteen cases. Had this ratio prevailed in the United States last year, the number of smallpox fatalities would have exceeded five hundred, instead of the thirty-three deaths that were actually reported.

In the cities, the figures for 1936 exceeded those for 1935. In 743 cities of the United States there were 1,710 cases as compared with 1,459 during 1935.

In this day of wide public interest in community health, such rates are inexcusable. Smallpox is a preventable disease. By the simple measure of general vaccination and revaccination, it can be entirely eradicated from any community. This has been proved time and again.

(Continued on Page 42)



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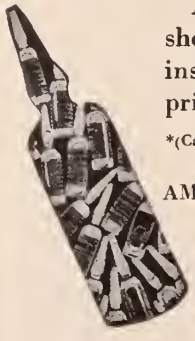
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*(Can. Med. Ass'n Jl. Dec. 1936)

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(Continued from Page 38)

In New York City, where the vaccination of all minors is compulsory, there has not been recorded a case of smallpox since 1932 and there have been only seventeen cases during the past ten years. In other cities where vaccination of school children is compulsory, smallpox cases are equally rare. For example, in Philadelphia, only four cases have appeared since 1926; in Boston there have been only fifteen cases, and in Newark, New Jersey, only ten cases during this period. There has not been a smallpox death in Newark since 1909, and, with the exception of 1925, there have been no deaths from this disease in Philadelphia since 1912.

None of the cities of 1,000,000 or more population in the United States reported high prevalence of smallpox in 1936; but there are records even within the last two decades of high incidence of the disease in certain of the large centers of population. Los Angeles, for example, as late as 1933, registered a smallpox sickness rate of forty-two cases per 100,000 population, and one of 137 in 1925. Philadelphia, whose excellent record since 1926 has just been mentioned, recorded 184 cases and a smallpox morbidity rate of ten per 100,000 in 1925. If cities of this size had suffered a visitation of smallpox comparable with that recorded in Sioux City, Iowa, last year (525 cases per 100,000 population), the number of smallpox patients would have exceeded 10,000.

"Benzedrine Sulfate" in Narcolepsy.—Ulrich (N. E. J. Med., 217:696, October 28, 1937), makes a second report on the treatment of narcolepsy with "Benzedrine Sulfate" (benzyl methyl carbinamine sulfate, S. K. F.). Some of his patients have now had continuous treatment for nearly two years.

Seven of the ten cases of narcolepsy were complicated by cataplexy. All had complete or marked relief on administration of "Benzedrine Sulfate" in doses varying from 10 to 60 milligrams a day, the average daily dose being 25 milligrams. In only one case was there an apparent tolerance developed. Cataplectic symptoms were particularly benefited, and did not reappear even after withdrawal of therapy.

No evidence of permanent deleterious effects or habit formation was found. Slight rise in blood pressure and basal metabolic rate was produced in some instances, but these effects were transitory. Anorexia and momentary discomfort were prevented by reducing the dose or changing the time of administration.

Two patients who suffered from obesity had an 11 per cent loss of weight with "Benzedrine Sulfate" in doses of 20 to 30 milligrams a day. This effect was not observed in patients of normal weight.

Ephedrine was tried in three cases of narcolepsy, but was found to be of slight or no benefit. Dibenzyl carbinamine, given to four patients, failed to relieve narcoleptic symptoms and produced gastro-intestinal reactions, especially in large doses.

The author concludes that "Benzedrine Sulfate" provides the only satisfactory treatment for narcolepsy, but cautions against unsupervised use.

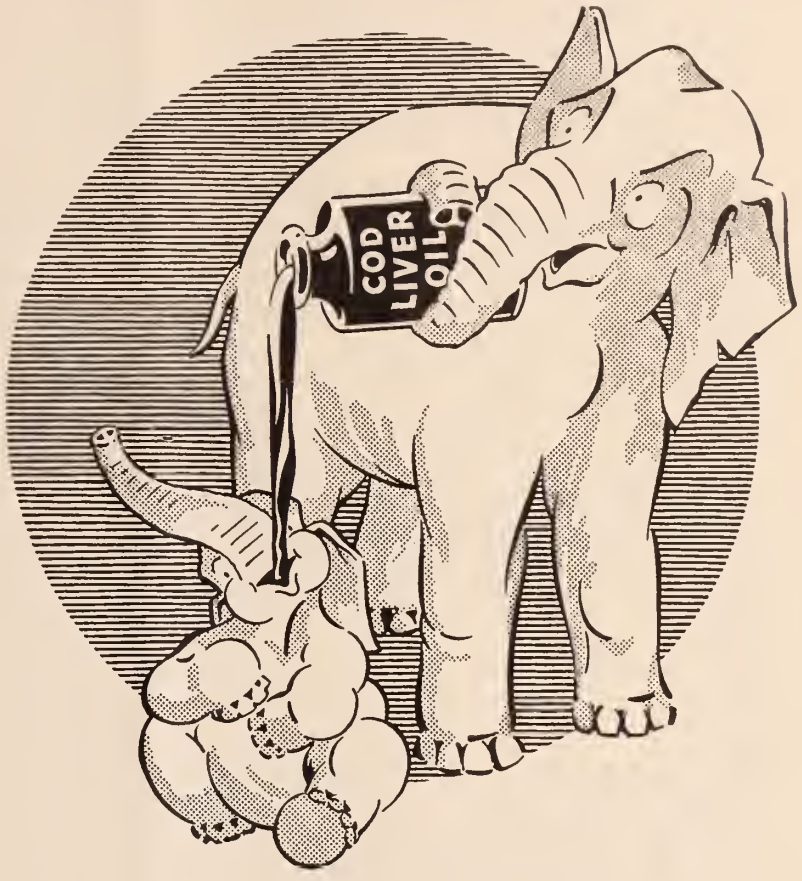
A Practical Handbook on Vitamins.—A most refreshing departure from the usual pharmaceutical manufacturers' effusions, on the overly discussed subject of vitamins, is represented by a new booklet which has just been released by E. R. Squibb & Sons, 745 Fifth Avenue, New York. The cover carries the title, "Physicians' Vitamin Reference Book."

The book is divided into several sections, seven describing from the clinical viewpoint, the requirements and deficiency manifestations, of vitamins A, B_1, G Complex, B_2, C, D, and E. Another section deals with multiple deficiencies and there is a list of other vitamin-like factors.

The description of each of the vitamins is preceded by a useful condensed summary. Estimated daily requirements of various vitamins are stated in International Units where these are available. The vitamin potencies of a number of foods, selected because of their relatively high potency and general availability, are also given.

The subject matter appears to have been carefully selected and conservatively presented, and it repeatedly

(Continued on Page 46)



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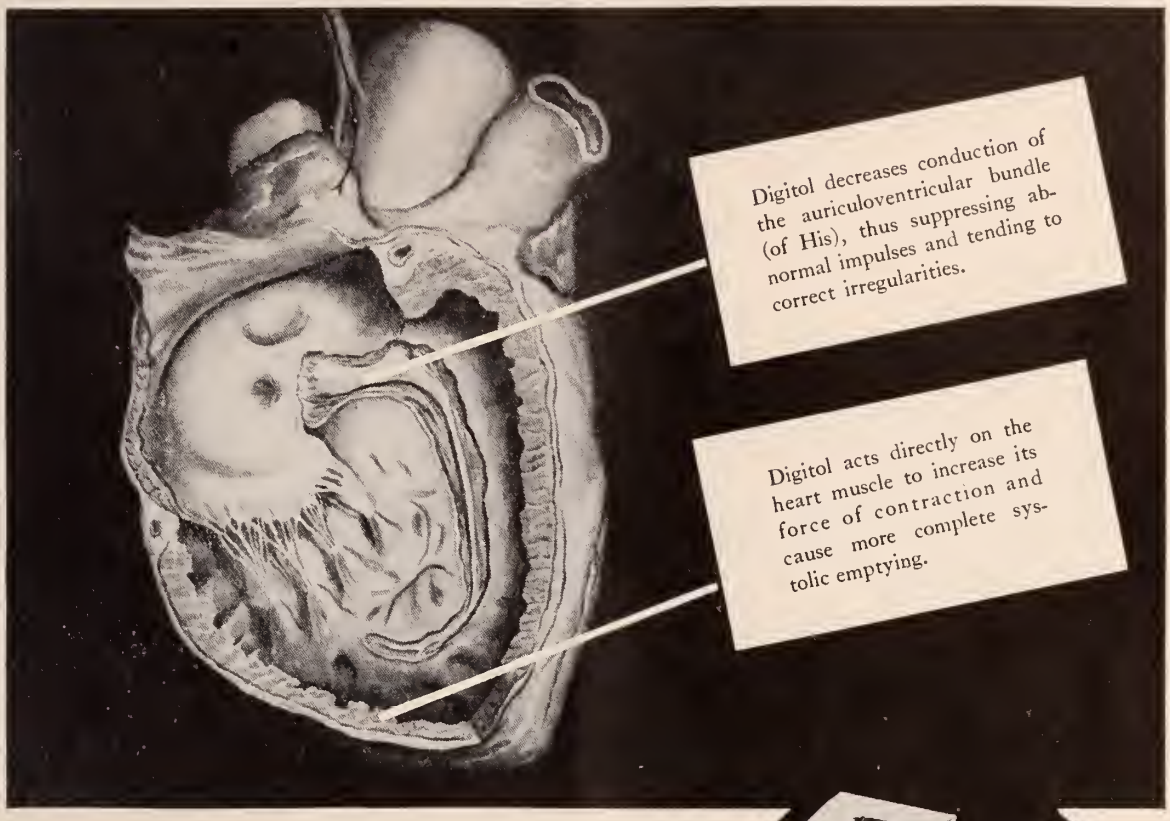
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(Continued from Page 42)

reproduces the attitude of the Council on Pharmacy and Chemistry toward the clinical use of the vitamins in certain pathologic states. With a frankness that is commendable, negative reports are cited without bias, leaving, as should be done, the choice of therapy strictly with the physician.

The book is not cluttered with extensive reports of animal nutrition experiments and deductions of possible clinical applications. Conservative clinical data are cited, whenever possible to show what may be expected therapeutically from the administration of the different vitamins. There is no historical section, but the chemistry of the vitamins is very briefly outlined.

The manufacturer does not state under what terms the book is available, so it must be inferred that any physician who is interested need only write to the firm to obtain a copy. The opportunity to secure so much useful information, so handily compiled, is relatively infrequent.

Posture.—"There is but one way to stand," says the *Journal of the American Medical Association*: "The head is up and the chin in and back; the head is balanced above the shoulders, hips, and ankles. The chest is elevated, with the breast bone part of the body farthest forward. The lower abdomen is in and flat, and the back curves are within the normal limits." It is not difficult to take this position because it means bringing the body to its natural lines and balance.

As a fundamental exercise to correct bad posture: Stand with the heels four inches from a wall, but with hips, shoulders, and head touching the wall. Flatten in the lower back against the wall by pulling in the abdominal muscles while strongly contracting the buttock muscles. All motion occurs at the waistline and hips. The shoulders are held perfectly still. Relax the contracted muscles and allow the lumbar curve to return. Now stand away from the wall, keeping the abdominal muscles in the lower back flattened. Raise the ribs and chest so that the breast bone is the part of the body farthest forward.

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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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In spite of the "attractive results obtained . . . and the apparent low toxicity of the drug," the author concludes that it is too early definitely to recommend "Benzedrine Sulfate" in the general treatment of pediatric behavior problems, and that additional studies should be made in this field.

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Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

San Mateo County Medical Society
President, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, E. J. Lamb, 1515 State Street, Santa Barbara.
Secretary, J. Jerome Rupp, 16 E. Junipero Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

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Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
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Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

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Meeting, *Second Sunday.*

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Meeting, *Sunday Evening once a month.*

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Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

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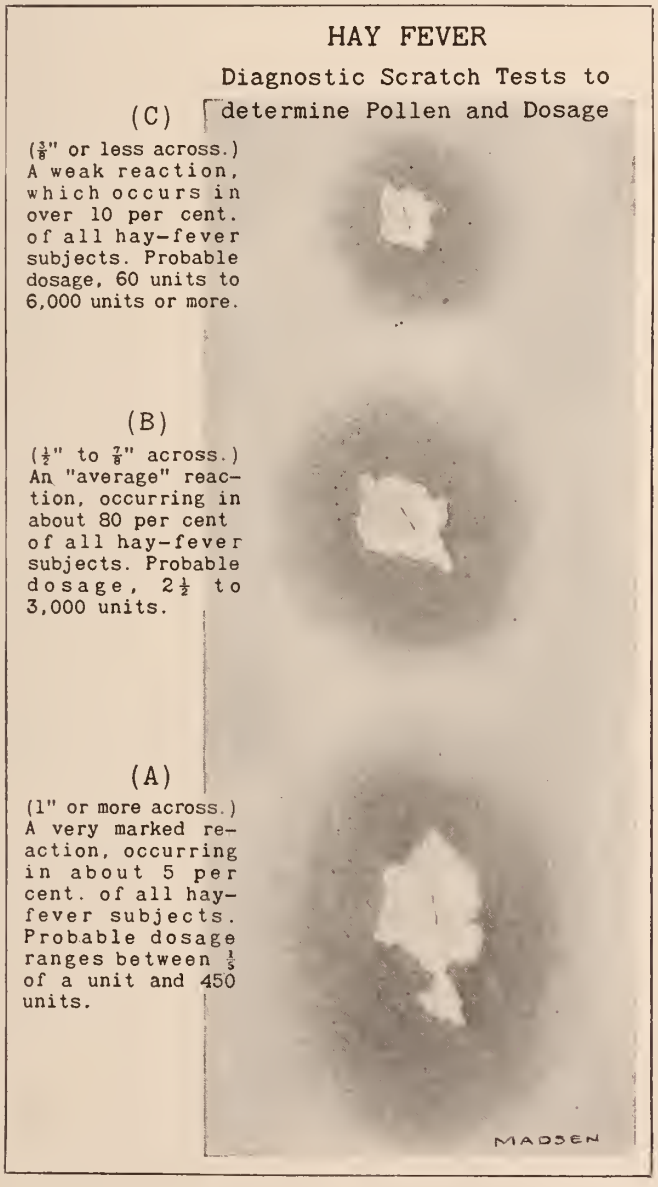
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Parke, Davis & Company Elects New President and New Finance Chairman.—Dr. A. William Lescohier was elected president of Parke, Davis & Company, and Norman H. F. McLeod, chairman of the Finance Committee, at a meeting of the Company's Board of Directors held in Detroit on March 1. Both men have been actively connected with the Company for about thirty years. Doctor Lescohier has been general manager and a director since 1929, and Mr. McLeod a member of the Board since 1921, and secretary and treasurer since 1923.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Handbook on Social Hygiene. Edited by W. Bayard Long, M.D., Attending Dermatologist and Director of Dermatology and Syphilis Clinics in St. Luke's Hospital, New York; Chairman, Social Hygiene Committee, New York Tuberculosis and Health Association, and Jacob A. Goldberg, M.D., Ph.D., F. A. P. H. A., Secretary, Social Hygiene Committee, New York Tuberculosis and Health Association, and Social Hygiene Council of Greater New York. With a Foreword by Edward L. Keyes, M.D., Professor Emeritus of Clinical Surgery (Urology) in Cornell University Medical College, New York; Honorary President, American Social Hygiene Association. Cloth. Pp. 412, illustrated with 62 engravings. Price, $4. Philadelphia: Lea & Febiger, 1938.

A Biological Approach to the Problem of Abnormal Behavior. By Milton Harrington, M.D., Psychiatrist, Institution for Male Defective Delinquents, Napanoch, New York, Formerly Consultant in Mental Hygiene, Dartmouth College. Cloth. Pp. 459. Lancaster, Pennsylvania: The Science Press Printing Company, 1938.

Claude Bernard, Physiologist. By J. M. D. Olsted, Professor of Physiology, University of California. Cloth. Pp. 272, illustrated. Price, $4. New York: Harper Brothers, 1938.

Clinical Methods. A Guide to the Practical Study of Medicine. By Robert Hutchison, M.D., LL.D., F.R.C.P., Consulting Physician to the London Hospital and to the Hospital for Sick Children, Great Ormond Street, and Donald Hunter, M.D., F.R.C.P., Physician (with charge of out-patients) to the London Hospital. Tenth Edition. Cloth. Pp. 658, with nineteen color and two halftone plates and 142 figures in the text. New York: Paul B. Hoeber, Inc., 1938.

A Textbook of Ophthalmology. By Sanford R. Gifford, M.A., M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago; Attending Ophthalmologist, Passavant Memorial, Cook County, Wesley Memorial and Evanston Hospitals. Cloth. Pp. 492, with 249 illustrations. Price, $4. Philadelphia: W. B. Saunders Company, 1938.

Treatment in General Practice. By Harry Beckman, M.D., Professor of Pharmacology at Marquette University School of Medicine, Milwaukee, Wisconsin. Third Edition, Revised and entirely reset. Cloth. Pp. 787. Price, $10. Philadelphia: W. B. Saunders Company, 1938.

How Ancient Healing Governs Modern Therapeutics. The Contribution of Hellenic Science to Modern Medicine and Scientific Progress. By Kleanthes A. Ligeros, M.D., Ph. D., Athens, Greece. Cloth. Pp. 523, fully illustrated. Price, $10. New York: G. P. Putnam's Sons, 1937.

Pneumonia and Serum Therapy. By Frederick T. Lord, M. D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; Member of the Board of Consultation, Massachusetts General Hospital; and Member of Massachusetts Advisory Committee on Pneumonia, 1931-1935, and Roderick Heffron, M.D., Field Director, Pneumonia Study and Service, Massachusetts Department of Public Health, 1931-1935. Revised Edition of Lobar Pneumonia and Serum Therapy. Cloth. Pp. 148. Price, $1. New York: The Commonwealth Fund, 1938.

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Clark: Appied Pharmacology, 6th ed. . . .	5.00
Davis: J. B. Murphy, Stormy Petrel of Surgery	3.00
McMurray: Practice of Orthopedic Surgery .	5.00
Strecker & Chambers: Alcohol, One Man's Meat	2.50

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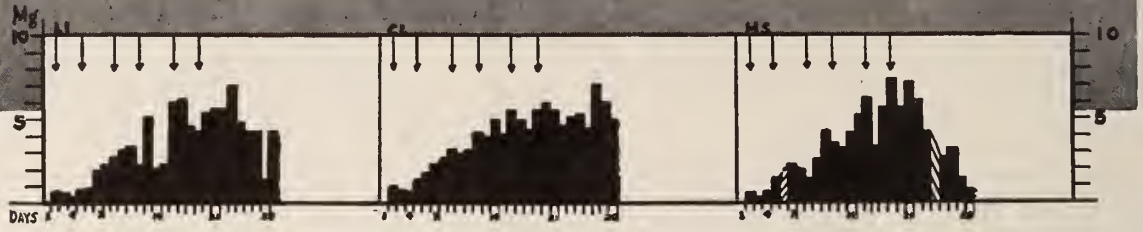
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[1] Sollmann, T., Cole, H. N., Henderson, K., *et al.: Amer. J. Syph. Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 304)

From an Article on "Psychiatric Duties of Large Cities" by Robert L. Richards, M.D., Medical Superintendent, Mendocino State Hospital.—To the community at large the important point about the insane is that they are unsocial or antisocial. The directing or dominating part of an individual is found in his mental faculties; when these are disturbed, his relations to others are disturbed, and he becomes unsocial or antisocial. The lack of community of interests and thoughts is one of the striking features of a hospital for the insane. The environment of these patients is parallel with that of soldiers in barracks, for example; and yet the reaction of the insane under these circumstances is radically different. Unless convalescent they rarely talk to one another, and usually on parole or in the wards each is thinking or talking about his own personal affairs, and paying no attention to anyone else. On this account, and contrary to the usual conception, a state hospital is quieter in general than an institution housing an equal number of sane people. By training and reëducation is secured an adaptation to a routine way of living, and a gradual resumption of social duties. The finer adjustments of social life are the latest acquisition of the human race, and naturally the point where mental derangements are first noticed, and where recovery is last established. Hence our chief interest is in the social manifestations of the insane.

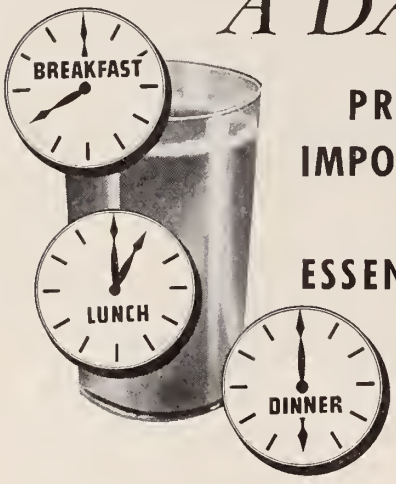
From an Article on "Are We Doing as Much for the Tuberculous Patient as We Should?" by Francis Marion Pottenger, M.D., Monrovia.—While the subject of my talk before you may be criticized because of its almost limitless scope, yet I shall attempt to treat it concretely and not in the rambling manner that might be suggested by the title. I shall attempt to discuss tuberculosis in the light of the recent advanced studies of its pathology and to bring to your attention the breach which exists between our ability to diagnose the disease early and the diagnosis which is usually made; the curability of the disease established by the best clinical methods and the result usually obtained; and the preventability of the disease as based upon both theory and experience, and the actual prevention which is being carried out.

From an Article on "Interauricular or Interventricular Deficiency of Septum? A Question of Diagnosis," by Dr. William Watt Kerr, San Francisco.—The symptoms and physical signs in this case indicate a septal deficiency, but it is difficult to decide whether the communication is interauricular or interventricular. The dusky color is comparatively slight, the mucous membranes are dark red, not blue, the patient never has suffered from an abnormal degree of dyspnea on exertion, he can perform his daily work even when it is laborious as actively as any of his associates, and very frequently after working all day he has run out to the Ocean beach and back again, a distance of more than six miles, just for the pleasure of the exercise.

From an Article on "Prospects and Retrospects" by A. Barkan, M.D., San Francisco.—This sketch of forty years' experience as a teacher and a specialist for eye, ear, nose, and throat in California was prompted by a friend, who asked to have it put before the medical profession of Vienna with whom I studied and worked forty years ago but from whose ways and works I have diverged under the influence of different conditions and obvious necessities. Although a specialist, I cannot avoid including general medicine in the field of my consideration, but I shall avoid figures and names. I shall present only those general ideas that my life work as a teacher and a physician have brought home to me, with such facts (outside of my own experiences) as my trips and visits to the medical centers of the East have enabled me to gather through personal observation.

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

From an Article on "Granuloma Inguinale Tropicum" by D. Friedlander, M. D., San Francisco.—The only excuse that I have to offer for the presentation of this paper, since it carries nothing original with it, is the fact that this disease is so infrequent in the temperate zone. In view of the constantly increasing number of tropical affections with which we come in contact, it seems to me that a résumé of the subject, together with the report of two cases occurring in San Francisco, might be of interest.

From an Article on "Some Conclusions Regarding the Present Knowledge of Vermiform Appendix by C. J. Teass, M. D., San Francisco.—The subject was prompted not alone from the constant erroneous expressions one hears through the laity, but from the thoughtless and unjust remarks made by members in the profession.

From an Article on "Treatment of Fractures of Patella" by Rexwald Brown, M. D., Santa Barbara.—Simple fractures of the patella in otherwise healthy individuals being, therefore, the indication for open operative measures to its cure, the technique of the operation, the time for its institution, and the postoperative procedures, are the chief matters for attention.

From Some News Notes From Newspapers:

Dr. J. B. Murphy of Chicago, principal promoter of the proposed "American Royal College of Surgeons," has been visiting in the southern part of the State.

"Los Angeles the Chemically Pure," is the title of a most brilliant and entertaining article in the March number of the *Smart Set*. It is a delicious morsel!

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Antityphoid treatment is to be administered to the students of the University of California, as they may request it. The announcement was made that the treatments would be begun March 24, and a very large number of students immediately filed the request. Probably, in time, antityphoid treatment will be as much a requirement as vaccination.

The California Eclectic Medical College, Los Angeles, dined a dozen of the legislators during the legislative vacation and devoted their energies to denouncing the American Medical Association, the Association of American Medical Colleges, and everybody who wanted to have medical men properly educated. It must have been an encouraging banquet—for the twentieth centurry!

The Los Angeles County health officer, Dr. E. O. Sawyer. is to investigate the islands off the southern California coast with the object of finding one that would make a suitable quarantine station for lepers.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 304)

Paul F. Eid, M.D., conviction of a crime involving moral turpitude. License revoked on March 10, 1938. (Previous entry, February, 1938.)

Oscar Charles Long, M.D., Federal narcotic conviction. License revoked on March 10, 1938. (Previous entries, June, 1935; March, May and December, 1936; February, July and August, 1937.)

Frank Adrian Pearl, M.D., convicted in the Los Angeles insurance fraud. License revoked on March 10, 1938. (Previous entry, December, 1937.)

James Willard Nicholson, M.D. Placed on probation on October 17, 1934, and charged with violation of the terms of his probation, was on March 10, 1938, found guilty and placed on probation for five years additional, during which time he is not to use alcoholic or intoxicating liquors and is to abide by all the laws of the State of California and the United States.

News

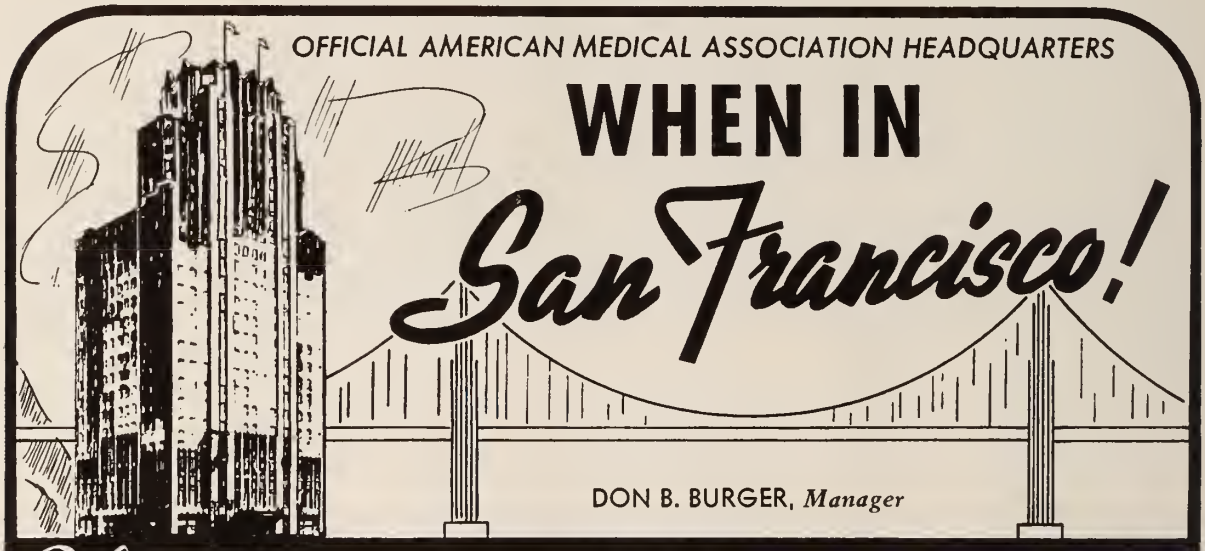
"The influx of foreign physicians because of political conditions abroad during recent years is providing medical licensing authorities in the United States with a serious problem. Various aspects of it were presented by Dr. Charles B. Pinkham, Secretary of the California Board of Medical Examiners, at the Congress on Medical Education and Licensure here this morning. . . . Since the native medical profession is already increasing faster than the population, the foreign influx will 'add a hundredfold to the already serious condition,' Doctor Pinkham said. The problem of foreign students includes both American students, who because of restrictions in enrollment cannot enter American medical schools and native graduates of foreign schools, who seek to practice in the United States because of economic or political difficulties in their own countries. . . . Doctor Pinkham reported that during the fiscal year ending June 30, 1936, 537 alien doctors entered the United States; the next year the number was 533. Of the 1936 group 312 were from Germany. Licensing Boards in the United States find it extremely difficult to validate the credentials of foreign medical graduates. . . . In the first place medical training in many foreign schools is inferior to that in the United States. In 1936 35 per cent of the 588 foreign graduates who were examined in the United States failed to pass the examination. . . ." (Associated Press Dispatch, dated Chicago, February 15, printed Berkeley *Gazette*, February 15, 1938.)

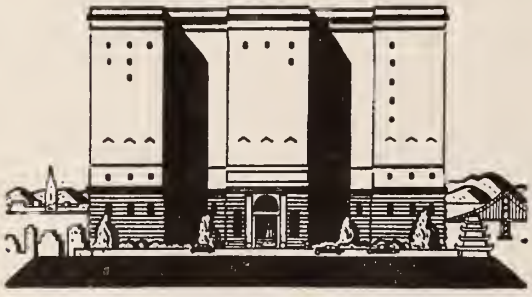
"Three years of investigation by the State Board of Medical Examiners culminated in conviction of 'Dr.' Richard Howard, Hacienda rancher, on two counts of violation of the medical practice act. . . . The charges on which Howard was convicted involved treatment of Amos H. Stanger, Dry Creek rancher, and his late wife, Mrs. Laura

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

Stanger, who died recently. Howard, it is charged, prescribed for and directed the treatment for the pair—selling them herbs which he prepared, along with a combination of epsom salts, baking soda and powdered bay leaves. . . . The verdict was reached after thirty minutes' deliberation. Howard faces maximum fines of $500 and not more than six months in the county jail on each of two counts." (Healdsburg *Scimitar*, February 10, 1938.)

"Richard J. Howard, self-styled 'doctor' of Hacienda, was fined $300 or one hundred days in the county jail by Judge Edward Quinn in Justice Court Monday morning, the penalty for violation of the State Medical Practice Act. On his plea of financial inability to raise the fine, Howard was granted a ten day stay of execution. . . . A long list of previous law violations and offenses was revealed in the probation report, running from 1929 until November, 1937, when the charges on which Howard was convicted were filed in Healdsburg Justice Court. Having come to California from Texas where reports indicated he had practiced medicine without a license, Howard was arrested for the same offense in 1929 in Shasta County, but was later released, the report asserted. In 1932 Howard was arrested in Sonoma County on a petty theft charge, but jumped bail, leaving the State, and was not extradited. After having been suspected of medical practice without a license in Calistoga and Santa Cruz, he was again arrested in Sonoma County for violation of the medical practice act in 1934. He entered a plea of guilty, the report says,

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and was placed on probation on a promise to desist. After failing to complete the case of conspiracy against Howard in the Justice Court in Guerneville, the district attorney's office prosecuted the case on a misdemeanor charge in Healdsburg Justice Court February 9, and obtained a conviction. . . ." (Healdsburg *Tribune*, February 28, 1938.) (Previous entries, December, 1929; June, 1932.)

"Conviction of a Sonoma County rancher for violating the State code governing medical practice emphasizes the importance of spreading knowledge that no one should permit treatment for disease at the hands of any but a regularly licensed physician and surgeon. In many instances persons have suffered for years or even died under such 'treatment' when their lives and health might have been preserved. In any case such unlawful practitioners delay proper medication to a point where science may be unable to help the afflicted." (Editorial, Santa Rosa *Press Democrat*, February 13, 1938.)

"Dr. George H. Parchen, chiropractor, yesterday was free for the third time on charges of performing illegal operations. Charges pending against him were dismissed by Judge Eugene Daney, Jr., in Municipal Court when Katherine Ellis, age 19, refused to testify that she was the victim of an operation barred by law. Her mother, Mrs. Mabel Ellis, had sworn to the complaint against Doctor Parchem." (San Diego *Union*, February 25, 1938.) (Previous entries, December, 1933; October, 1934; January and April, 1935.)

"Dr. Louis LaVine, Los Gatos chiropractor, faces a $3,382 judgment awarded Friday to Mr. and Mrs. C. O. Wallace of Los Gatos by Superior Judge Maxwell McNutt of San Mateo County, in San Jose. Judge McNutt allowed $3,000 general and $382 special damages for the alleged unskillful treatment of Mrs. Wallace's fractured arm a year ago. Asking damages of $8,625, Mrs. Wallace testified that Doctor LaVine placed a cast on her arm so tightly that it restricted circulation, resulting in her arm becoming withered. Doctor LaVine was arrested last spring, in connection with the same case, on a charge of violating the State Medical Practice Act, on complaint of Thomas P. Hunter, agent for the State Board of Medical Examiners. A jury acquitted the chiropractor. Doctor LaVine filed suit, now pending, for $10,300 damages against the Wallaces, Dr. R. E. Graun, Dr. William R. Harder, and Thomas P. Hunter, charging malicious prosecution." (Los Gatos *Mail News*, February 24, 1938.) (Previous entries, August, September, November, and December, 1937.)

"State medical authorities, working with District Attorney Matthew Brady, last night arrested a massage parlor operator on charges of violating the medical practice act. The woman arrested was Jean Adams, 2511 Sacramento Street. Assistant Special Agent Joseph W. Williams of the State Medical Board, who made the arrest with Policewoman Ada Kennedy, accused Mrs. Adams of bilking a 25-year-old woman for six months with treatment for a nonexistent social disease." (San Francisco *Examiner*, March 2, 1938.)

"Convicted nearly two years ago of conspiring with a group of doctors who specialized in illegal surgery, William Byrne, former investigator for the State Medical Board, finally escaped a prison term today. Byrne, who has been in jail for sixteen months while he unsuccessfully appealed his conviction, must serve another year behind jail bars, however. The former state official appeared yesterday before Superior Judge Arthur Crum on probation plea. Following his conviction, along with a group of doctors in October, 1936, Byrne had been sentenced to prison by Judge Crum. Heeding a plea on the part of Attorney Russell Parsons that Byrne's rehabilita-

(Continued on Next Page)

Helium-Oxygen Mixtures used in treatment of asthma

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

tion should begin now, Judge Crum suspended the prison term, placing the defendant on probation for ten years and ordered him to spend the first twelve months in jail. According to the testimony on which he was convicted, Byrne conspired with a group of doctors who opened a series of illegal surgery 'clinics' in California, when he should have arrested them." (Los Angeles *Examiner*, February 10, 1938.)

"A socialized medicine plan, under which families would pay a monthly fee to insure medical care in time of sickness or accident, was declared illegal here today by Attorney-General U. S. Webb. Webb told Dr. Charles B. Pinkham, secretary-treasurer of the State Board of Medical Examiners, that circulars of the so-called 'health foundation' indicated the plan violated the State business and professions code which prohibits the practice of medicine 'under a fictitious name.'" (Riverside *Press*, February 21, 1938.)

"Dr. G. O. McKeehan, well-known southeast district physician, Friday stood free of charges he was an 'ambulance chaser' in connection with 'fake accident' frauds. Dr. McKeehan, defended by Attorney W. LeRoy Thomas of Huntington Park, stood trial on charges of violation of State 'ambulance chasing' law, a measure designed to prevent doctors from soliciting business for attorneys. After hearing evidence for two days, Deputy District Attorney George Thalman moved to dismiss charges against Dr. McKeehan in Superior Judge Frank M. Smith's court. Thomas stated he 'had every reason to believe that Dr. McKeehan will receive leniency' when he appears for sentence on charges of conspiracy to defraud in connection with the previous 'fake accident' charges. The jury found Dr. McKeehan guilty; also recommended leniency, Thomas stated. . . . Dr. McKeehan was arrested following the arrest of George O'Dell Dorris and Mr. and Mrs. Weir McKean in Huntington Park, during 'fake auto accident' activity. Dorris' alleged confession implicated Dr. McKeehan, investigators asserted, and charges were filed against him." (Huntington Park *Signal*, February 18, 1938.)

"The toll of convictions and guilty pleas in the State Bar's campaign to smash Los Angeles' 'fake accident' ring, reached thirty-nine yesterday when Attorney Louis Feinstein and Dr. W. B. Humphrey were convicted on two counts each of soliciting the commission of a crime. (653-f Penal Code.) The jury in Judge Frank M. Smith's court was out twenty-eight minutes after a two weeks' trial. First information on the workings of the ring was turned over to District Attorney Buron Fitts' office in May, 1937, by Herbert S. Hallner, special operative for the State Bar. Fitts assigned Deputy District Attorney George Stahlman to prosecute the cases. Sixty persons were indicted by the grand jury. Numerous guilty pleas and convictions under the vigorous work of Stahlman and Hallner followed. Several physicians were found guilty of entered pleas, although Feinstein was the first attorney to be convicted. Six other attorneys and fourteen physicians were scheduled to appear before Judge Bull next Tuesday in a further phase of the racket-smashing campaign. They are charged with an ambulance chasing conspiracy, a felony under a

(Continued on Page 22)

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BOARD OF MEDICAL EXAMINERS

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city ordinance. . . . Maximum penalty for the felony conviction is ten years in prison. However, Superior Judge Frank M. Smith, in whose court the case was tried, has the alternative of reducing the charge to a misdemeanor, in which the maximum penalty is two years in jail or a $10,000 fine for each defendant. Fake accidents had netted conspirators approximately $500,000 until evidence of them was laid before the district attorney's office, by Attorney Hallner, according to the district attorney's office. The sweeping grand jury indictments followed." (Los Angeles *Journal,* February 4, 1938.)

"A thirty-five-page indictment embodying two conspiracies and 130 overt acts linking fifteen doctors, lawyers and laymen in an asserted gigantic district ambulance chasing ring was read in Superior Judge Frank M. Smith's court this week at the first trial of its kind in the history of the country. . . . Drs. E. D. Abraham, John E. Porter, and P. C. Lawyer gained dismissals on the understanding by the prosecution that they would turn state's evidence, it is reported. Doctor Abraham has denied this report, stating that he is in no way involved in the case. He has been 'excused from trial,' he asserted." (Huntington Park *Bulletin,* February 14, 1938.)

"Charged with implication in a $500,000 'fake accident' ring which operated in the Southeast district, fifteen men, all physicians or attorneys but one, this week went on trial in Superior Judge Frank M. Smith's court. The men were indicted several months ago on charges of conspiracy to violate the ambulance-chasing laws. . . . Of the original twenty-two persons indicted, four doctors pleaded guilty, one layman was sentenced to San Quentin. In another

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case, one doctor gained a dismissal on conviction in another case, and another doctor submitted his fate on the transcript of the preliminary hearing without standing trial. Those who went to trial this week were: Drs. W. B. Humphrey, M. C. Cooley, E. H. Anthony, John E. Porter, G. O. McKeehan, P. C. Lawyer, E. D. Abraham, and F. A. Pearl." (Los Angeles *Bulletin*, February 10, 1938.)

"Dr. W. B. Humphrey, one of a group of seven attorneys and doctors on trial on conspiracy charges growing out of their alleged affiliation with an asserted ambulance-chasing ring, yesterday halted the trial when he rose suddenly and pleaded guilty to the charges. Doctor Humphrey has already been convicted in another case and is awaiting a probation hearing next March 24. . . . Doctor Humphrey's plea of guilty left only one physician on trial, Doctor E. H. Anthony. . . ." (Los Angeles *Daily News*, February 18, 1938.)

"Superior Judge E. J. Tyrrell of Oakland yesterday granted Mrs. Annabel MacLellan, forty-six, and Mrs. Lucille Bouton, fifty-one, two years' probation on their plea of guilty to charges of conspiracy to perform an illegal operation. Mrs. MacLellan is the widow of Dr. Gordon L. MacLellan, San Leandro physician, who committed suicide last October rather than face similar charges. The operation allegedly was performed last year by Doctor and Mrs. MacLellan with Mrs. Bouton as nurse." (San Francisco *Chronicle*, February 10, 1938.)

"Something should be done about Gypsy 'healers' who use their patients' money to pay off their own doctor bills. Mrs. Pearl Heller of 1040 Temple Street, told district attorney's investigators yesterday. The investigators listened to Mrs. Heller's story of how she lost $1,000, agreed with her, and issued a complaint naming Mrs. R. Kasko, alias Isabel Sherlock, alias Isabel Brewer, Gypsy of 1119 West Sixth Street who is reported missing. Mrs. Heller, still suffering from injuries received several years ago, told Deputy District Attorney Howard Hinshaw she consulted Mrs. Kasko at 501 South Figueroa Street, after reading an advertisement. She said she was told to bring $300, have it 'blessed' and to carry it on her person. She followed directions. Last January 27, as instructed, she declared she drew $700 more from a bank, and added it to the $300. Finally, on last Wednesday, Mrs. Heller said she was told to leave the entire sum with the healer, which she did. Back-tracking on the trail of the $1,000, it was learned that on the day after Mrs. Heller allegedly surrendered her 'blessed' cash, the Gypsy paid Dr. W. P. Cook, 1136 West Sixth Street, his bill for medical services to the 'healer' totaling $700. If and when Mrs. Kasko is found, she will be charged with grand theft." (Los Angeles *Daily News*, February 8, 1938.)

"'Dr.' W. J. Bolle, self-styled naturopath and conceded Don Juan, has been indicted by the Marin County Grand Jury on charges of bigamy, grand theft and issuance of fictitious checks. Bolle, now in custody in the east for impersonating a Federal officer, will be returned here for trial after the other sentence is disposed of, District Attorney Albert E. Bagshaw said. The 'doctor,' former operator of a Texas lovelorn correspondence club, assertedly married two bay district women before leaving here. One, Mrs. Evelyn Hough of Martinez, testified before the Grand Jury. The other Miss Areta Lofthouse, San Anselmo nurse, from whom he assertedly took a car and several hundred dollars." (Oakland *Tribune*, February 9, 1938.) (Previous entry, November, 1937.)

"After thirty years of successful practice as a physician and surgeon, Dr. Allen H. Peek of Ventura, formerly of Oxnard, announced today that he is retiring from practice. . . ." (Oxnard *Press*, February 10, 1938.)

(Continued on Next Page)

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"An echo of the statewide abortion ring, of which R. L. Rankin was reputed master mind, was heard today when the Federal Grand Jury voted income tax evasion indictments against two men once indicted in connection with the ring's activities. After today's indictments, bench warrants were issued for Lawrence J. Giubbini, Livermore chiropractor, and Marvin Raithel, former druggist. Bail for Giubbini was set at $5,000 and for Raithel at $1,000. Giubbini was accused of evading payment of taxes on an income of $12,439 in 1934 and $9,629 in 1935, while Raithel's indictment was based on incomes of $10,095 in 1934 and $3,445 in 1935. The indictments were the result of two years of work by Internal Revenue Department investigators under the direction of Ralph Reed, the investigation dating back to the time when the abortion ring was most active. The two men were among the twenty-three persons indicted here as the result of the death of Vivian Dryden of Oroville. Raithel turned state's evidence, while charges against Giubbini were dismissed." (San Francisco *News*, March 11, 1938.)

Investigation reports relate Paul Fowler, licensed chiropractor, on February 4, 1938, in Los Angeles Municipal Court was sentenced to serve 180 days in jail, the court denying motion for new trial, whereupon Fowler filed notice of appeal and was released on $15,000 bail. (Previous entry, February, 1938.)

"Back from a brush with death, Mrs. Dorothy Marks yesterday told San Francisco police a story of terror and pain. On the basis of the pretty Oakland woman's evidence, Mrs. Ann Brown, sixty-eight, of 1304 Fillmore Street, was jailed on a charge of committing an abortion. . . . Last Sunday the young Oakland woman said she went to the Fillmore Street flat and paid Mrs. Brown, whom she knew as 'Mrs. Emerson' to perform an abortion. Details of a crude operation performed on a kitchen table were given the San Francisco inspectors. Mrs. Marks remained at the Fillmore Street address until Tuesday, when she returned to the hotel in Oakland. On Saturday, Mrs. Marks called Dr. George V. Vandervert. Doctor Vandervert found the young woman seriously ill from an infection, and so reported to police. The physician yesterday declared Mrs. Marks will recover. Inspectors took Mrs. Brown to Mrs. Marks' room. There, Mrs. Marks identified Mrs. Brown as the woman she employed for the abortion. At the City Jail, officers said Mrs. Brown was arrested under the name of Jane Wright on October 22, 1927, and charged with performing an abortion. She was acquitted." (San Francisco *Examiner*, March 14, 1938.) The files of the Board of Medical Examiners show Jane Wright arrested on November 26, 1937. Off calendar pending outcome of felony-abortion charge.

United States Department of Agriculture: Federal Food and Drug Administration.—Seizures recently made under the authority of the pure food law involved a variety of foods found to be dirty or decomposed, the current report of the Federal Food and Drug Administration shows. There were fifteen seizures of scattered small lots of fudge bars and similar candy, the output of one manufacturer. . . .

Parasitic infestation led to confiscation of 300 pounds of whitefish. Insect infestation accounted for the confiscation of 45 cases of canned mustard greens, 970 jars and 1,932 cans of apple butter, 230 cases of canned "field peas with snaps," and 19 cases of tomato catsup. Eight cases of tomato paste showing a high mold content also were seized. The remainder of seizures on grounds of decomposition involved 35 sacks of rabbits, 1,600 pounds of skim-milk powder, 5 cases of canned clams, and 26 cases of canned celery-and-tomato juice.

A survey of the output of certain alimentary paste manufacturers revealed an insistent use of artificial color in

(Continued on Page 26)



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57

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noodles purporting to be "egg noodles," but found to contain little or no egg. . . .

Potatoes, Onions, and Canned Foods Seized

Three carloads of potatoes were seized when examination revealed a form of internal decomposition known as net necrosis, rendering the tubers unsuitable for food.

Substandard canned foods not labeled in accordance with the regulations promulgated by the Secretary of Agriculture, were seized in the following quantities: 660 cases of canned cherries, 218 of "diced" pears, 4,390 of peas, and 372 of tomatoes.

The roundup of flavors and solvents containing poisonous glycols continued during January, the report states. A total of 287 gallons in large containers, and 12,625 small bottles were seized. One hundred six bushels of apples were also confiscated on account of high arsenic and lead residues.

Drug Preparations Seized

Drug preparations and related products were seized as follows: 86 bottles of substandard chloroform, 280 bottles of substandard hydrogen peroxid, short in volume, and containing four times the declared amount of acetanilid; 4 gallons of "Astra-D" (an oil vitamin preparation) containing less vitamin D than represented; 350 boxes of a glandular preparation called "Endofollicolina," not of the claimed strength; 2,835 gross of defective mechanical prophylactics; and the following patent medicines allegedly bearing false and fraudulent therapeutic claims; Arthox, Diatene (a diabetes medicine), Femisan Suppositories, Kolorok, McDonald's Crystalene (for dropsy, diabetes, and rheumatism), Pinolator, Renolin (a dangerous cinchophen preparation), San-Nap-Pak Mentholated Kerchiefs, Tricasco, and Vegetrate Formulas A-45, A-417, D-44, and H-410.

Drug Case Terminations

Drug case terminations during the month are reported as follows: for shipments of pharmaceuticals below the official standards, Levy Products, Inc., Tampa, Florida,

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fine $50, and Crescent-Kelvan Company (George T. Lambert, George D. Lambert, and David Pereira), Philadelphia, Pennsylvania, fine $850; and for patent medicines labeled with false and fraudulent medicinal claims, Dr. Parker Medicine Company, Chicago, Illinois (Dr. Parker's Tablets), fine $600; Quaker Herb Company; and William Barth, Cincinnati, Ohio (Vita-Mil), fine $200; T-Lax Products Company, and Clemmie L. Carmichael, Bessemer, Alabama (aspirin tablets), fine $25, and Carmichael placed on five years' probation; W. D. Taylor & Company, and Clemmie L. Carmichael, Bessemer, Alabama (Kroup Monia Cough Syrup, Kroup Monia Penetrating Salve, and Taylor's Red Oil Liniment), fine $25, and Carmichael placed on five years' probation; Tampa Drug Company, and William G. Allen, Tampa, Florida (Dr. Isaac's Big Jim, and Dr. Isaac's Big Jim Healing Liquid), fine $35; Dr. Ward's Medical Company, Winona, Minnesota (Cough Syrup, Poultry Antiseptic and Astringent, Colic Remedy, and Anti-Pain Remedy), fine $80.

Government Loses Five Cases

Five cases were terminated unfavorably to the Government. In one, involving an alleged departure of a pharmaceutical product from official standard, the court returned a decision of not guilty. Two other pharmaceutical cases were dropped on motion of the United States Attorney because of their extreme age, and one case involving the shipment of a swine remedy and other stock medicines was dismissed by the court because of a fine imposed recently in a similar action against the products. In the fifth adverse termination, the court held that there is no fixed and definite standard to maintain a verdict of guilty in a case alleging deficiency of fruit in preserves.

Fernand Bezançon Elected President of Académie de Médecine.—The internationally known phthisiologist, Prof. Fernand Bezançon has been elected president of the Académie de Médecine of Paris for 1938. This is a well-merited recognition of the many contributions made by Professor Bezançon to the diagnosis and treatment of pulmonary tuberculosis.

Scientists' Habits Scored: Inventor Deplores Ponderance and Lack of Creative Minds.*—Scientific world progress is being held back by two factors, Charles F. Kettering, famed inventor and head of General Motors Research Corporation, said in Miami, Florida, on March 1, as he put the finishing touches to the latest of his many mechanical "brain children."

Those stumbling-blocks are:

The propensity of scientific men to cloak their ignorance with a mass of unintelligible terms and an aura of mystery, and the great lack of creative minds.

Measures Sun

Kettering—"Boss Kett" to those who work with him—has been in Miami for the past month developing a sunshine recording machine by which greater accuracy may be attained in obtaining constant measurement of the sun's intensity.

"We don't know very much about anything," said the man who invented the self-starter, an efficient Diesel engine, the artificial fever machine, and countless thousands of other devices. "We're so terribly ignorant, and if we'd only admit it instead of hiding our ignorance behind high-sounding scientific terms, we'd go farther.

Scores Pretentions

"For that matter," he continued, "we never know just how far we will go scientifically when we start to investigate some problem. All we can do is keep on the road and hope we'll come out somewhere. The trouble with most of us scientific fellows is that we hate to admit we don't know it all, and we keep ourselves back by pretending to have knowledge we don't possess."

Yet, in his opinion, the second stumbling-block to scientific progress is equally important. The world's dearth of creative minds is to him one of mankind's tragedies.

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(Continued on Next Page)

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

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(Continued from Preceding Page)

Admits Engineering

"Some persons seem to think that science has gone so far that culture and social progress have been unable to keep pace," he said. "That, of course, is foolishness. When a man picks up a telephone in Miami to talk to London or Paris, the trouble with the picture isn't the telephone; it's that so few men would ever have anything important enough to say over such a distance."

Kettering has often described himself as a "pretty fair engineer" and will admit to no other prowess.

Says Engines Simple

"There's nothing mysterious about science," he said. "Take Diesel engines, for example. They seem to be highly complicated mechanisms, but the fundamental principle on which they are run was in use by natives of Burma hundreds of years ago.

"All so-called internal combustion engines, as you know, operate on the fire-making principles. There are three divisions to that principle: fire by friction, as illustrated by the common match; fire by spark, as illustrated by the flint and steel, and fire by pressure.

"All So Simple!'"

"Gasoline motors run on the fire-by-spark method; you build and extinguish three hundred fires a second when running your car. The Diesel engine, on the other hand, uses the fire-by-pressure system.

"Burma natives used to start their cooking fires by taking hollowed-out elephant tusks and compressing the air in it with a plunger. That is precisely what is done in a Diesel engine; air in the cylinders is compressed until it gets hot enough to ignite the fuel in the bottom.

"You see, it's all very simple."

Developing Motors

Kettering admitted, however, that in the last five years his company has spent $18,000,000 on the development of Diesel motors. "Working out little details," he explained.

In the final analysis, Mr. Ketterling believes, the future of all transportation and power hinges on the ability of science to capture the energy of the sun. He has for years been intensely interested in research on plant chloryphyl—the stuff leaves produce as a result of absorbing sun's rays. He called it "the most important research being conducted today," and averred that thus far science has failed to do little more than take what little sun energy plant life has already absorbed.

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"We dig coal from the ground and pump petroleum and use the energy it was given by the sun," he said.

"What we must do now is learn how to use today's sunshine rather than the sunshine of thousands of years ago. But we're so ignorant!"—*Los Angeles Times,* March 2, 1938.

Bread for Washington's Army.—Christopher Ludwig, a baker of gingerbread in Philadelphia, was the first man to be appointed by Congress as "Superintendent of Bakers and Director of Baking in the Grand Army of the United States." This appointment, together with a salry of $75 a month and two rations a day, was made in May, 1777, three years after the opening of the Revolutionary War.* For this amount, because of his patriotism, Ludwig gave up a thriving business and undertook to see that the soldiers were regularly supplied with good bread.

* Excerpt from Journal of Congress, Saturday, May 3, 1777: Resolved, That Christopher Ludwig be appointed superintendent of bakers, and director of baking, in the grand army of the United States; that he have power to license, with the approbation of the commander in chief, or officer commanding at any principal post, all persons to be employed in this business, and to regulate their pay, making proper report of his proceedings, and using his best endeavors to rectify all abuses in the article of bread: That no person be permitted to exercise the trade of baker in the said army without such license; and that he receive for his services herein, an allowance of 75 dollars a month and two rations a day.

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Before the Director of Bakers was chosen, bread making in the army had been a very haphazard proceeding. Instead of rations of bread, the men were given an allotment of flour daily. Sometimes they tried baking their own bread on hot stones, but because the "fire cakes" were so unsatisfactory it was more usual for them to pool their flour and have some comrade do the baking. This led to bad practices, because these chosen bakers returned one loaf of bread for a pound of flour, using as much water as they pleased and keeping for themselves the flour that was not needed for each loaf. This extra flour they used to trade with the civilians. There is a record of bakers who made such huge profits in this way from a regiment (about three hundred men) that they were able to lend the commissary one thousand flour rations for eight days.

All this changed when Ludwig took charge. In setting his salary, it was suggested that as a special plum he be allowed to deliver only eighty loaves of bread for every hundred pounds of flour supplied to him. This he flatly refused to do, saying that 100 pounds of flour should yield 135 loaves of good bread and that that was what he proposed to deliver.

The men preferred hard bread which in some ways made things easier, but one of the greatest difficulties was to get flour and another was to get the bread delivered to the men in fit condition because no one was designated by army or congressional orders to take charge of it after it left Ludwig's care. Sometimes it moulded and sometimes it crumbled beyond the point of any use, and everyone sidestepped responsibility.

However, after petitioning Congress, and getting results, it was arranged that the flour should be supplied by the commissaries of the different divisions and posts, that bakers could be hired from outside, and that transportation be provided. No provision was made, however, for the salaries of hired bakers, and so Ludwig sold his houses in Philadelphia and took his business savings, some 3,500 pounds, to pay the men from his own pocket. As the army spread, and shipping had to be done over longer distances,

(Continued on Next Page)



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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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(Continued from Preceding Page)

locked wagons were supplied to deliver the bread to the camps, and money ($1,000) was appropriated by Congress to build brick ovens and hire workmen. Even with all this help of baking-posts, wagons, and men, the bread supply was seldom a week ahead of consumption, and sometimes less. Shortage of crops and dried watermills added to the troubles of poor Director Ludwig, as well as roads clogged with rain, grain speculators houding out for high prices, and grain-damaging rains. Bakers deserted, personal resources were nearly exhausted, rations were cut, and new baking centers were organized. Finally, in 1782, after Ludwig had kept hard at it in his central plant at West Point, the crisis was passed.

One interesting and strategic move was accomplished with the aid of the French bakers. Acting under orders, they began with a great stir to build ovens and make preparations for the establishment of a baking unit at Chatham, New Jersey. This completely misled the British commander, Sir Henry Clinton, into thinking that Washington intended to attack New York. In the meantime, Washington was pushing on to his real objective, Cornwallis, and by the time Clinton realized that a ruse had been accomplished the army was at Philadelphia and it was too late for the British to stop them.

Better Diets Main Factor in Preventing "Human Erosion."—If a raise of $100 a year in wages or salary comes to a family in a small city, the dining table will reflect the increase, but the previous income of the family will make a difference in how much more is spent for food. Those in the lower income groups with earnings of less than $1,500 a year probably will put about $20 of the raise into food. The families with incomes of from $1,500 to $3,000 probably will add $10 out of the $100 to food spendings, and the groups with incomes of more than $3,000 will average spending about $3 out of the added $100 for food.

Dr. Hazel K. Stiebeling of the Bureau of Home Economics contributed these figures to the symposium on con-

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servation of human resources at the Washington Hotel on March 4 in an address in which she traced the connection between inadequate diet and "human erosion," and emphasized that an abundant supply of well-chosen foods can "raise health from levels generally accepted as average or usual to definitely superior planes. Fully adequate diets are a conservation measure in the finest sense of the word.

"The potential increase in the market for food is among the lower income groups. They are the ones who most need more and better food. They are the ones who would be most likely to spend more money for food if they had it. One possible way of insuring more food to low income groups is by increasing incomes without increasing food prices. An alternative is to lower food prices without cutting incomes." For rural families the most practical way of improving the diet in many cases is by increase in home production of fruits, vegetables, and milk.

Commenting that some short-time demonstrations tend to show that human beings respond to diets in much the same way as some of the laboratory animals, Doctor Stiebeling said: "Observations upon generation after generation of laboratory animals indicate that superior diets result in somewhat more rapid rate of growth in the young and somewhat larger size at all ages. They contribute to greater than average success in the rearing of young; and, more important, they make the body more able to resist and cope with infection, and also significantly prolong the prime of life."

Plenty of fruits and green vegetables and plenty of milk and milk products are the main features in which the good diets are likely to differ from the diets that are inadequate or poorly balanced. These are the items which nutrition specialists group as the "protective foods" supplying the

(Continued in back advertising section, page 35)

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EDITOR GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

ANNUAL SESSION—PRE-CONVENTION BULLETIN SUPPLEMENT

April Supplement Should Be Read.—Members of the California Medical Association are urged to scan the pages of the Annual Session—Pre-Convention Bulletin Supplement to this April issue of CALIFORNIA AND WESTERN MEDICINE, in order to acquaint themselves, not only with the scientific work which their essayist colleagues have been pursuing during the last year, but also to learn somewhat more concerning some of the major organization problems to which the officers and committees of the Association have been giving careful study.

* * *

Scientific and Organization Programs.—An inspection of the pages of this Supplement will promptly indicate how large a constituent state unit in organized medicine is the California Medical Association, and how varied and important are the interests of its membership. The lists of papers on scientific topics offered by its twelve scientific sections (Anesthesiology, Dermatology and Syphilology, Eye, Ear, Nose and Throat, General Medicine, General Surgery, Industrial Medicine and Surgery, Neuropsychiatry, Obstetrics and Gynecology, Pathology and Bacteriology, Pediatrics, Radiology and Urology) are sufficiently attractive to lead every member to ask himself why he should not make an effort to attend this coming 1938 annual session? It will hold its first general meeting on Monday, May 9, in the beautiful Hotel Huntington at Pasadena, with succeeding meetings continuing through Thursday of the same week. The Committee on Scientific Program and the Section officers have made earnest efforts to present programs of sufficient worth to maintain real interest throughout the four-day session. Perusal of the synopses of the papers will prove convincing on these points.

* * *

Pre-Convention Bulletin "Reports."—Part II of the Supplement is given over to the Pre-Convention Bulletin, in which appear the reports of the general officers, councilors, standing and special committees. Here, also, a perusal of the text at once makes apparent that official position in

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Association activities implies more than empty honor. The printed reports only scratch the surface of the work and problems discussed, some of which will no doubt receive extended consideration by the House of Delegates and its Reference Committees. It is to be hoped that all members of the Association will take the time to at least glance at the reports submitted, and if suggestions occur to them in such reading, that members will communicate with their delegates so that proper consideration may be given to their opinions. The House of Delegates will meet on Monday and Wednesday evenings, and its Reference Committees will be in session throughout most of Tuesday and Wednesday, to consider the printed reports and the suggestions of members who wish to make any comment. Every member has the right, and should feel free to appear before the Reference Committees and present any matters having to do with medical practice which he deems worthy of study by the Association's officers. The office hours of the Reference Committees will be posted on the bulletin boards.

* * *

Other Annual Session Activities.—Attendance at the annual session need not be limited to listening to papers by guest-speakers and members, since an excellent scientific exhibit can be visited. Also a commercial exhibit, which all members are urged to inspect inasmuch as it is these exhibitors who, through their advertising coöperation, make possible, in part, the official journal of the Association. The representatives of the drug and publishing houses, and other firms who will display their products, will appreciate your visits to their booths, and such interest will be a gracious return for their indirect financial coöperation.

* * *

Hotel Accommodations at Annual Session an Increasing Problem.—With a membership of almost six thousand physicians, the California Medical Association is finding it increasingly difficult to find hotels of size, ample to care for the activities that are a regular part of its annual session. Space must be provided not only for general meetings, and for gatherings of twelve scientific sections, but for the House of Delegates, the Council, the Scientific and Commercial Exhibits, and the Woman's Auxiliary. Even so large a hotel as the Huntington is lacking in space for all these, so that it has been necessary for the Association to erect a special pavilion for exhibit displays. The Woman's Auxiliary will have its registration headquarters and some of its activities at the Hotel Huntington, but certain other of its meetings will be held at the Hotel Vista del Arroyo.

* * *

Transportation and Other Items.—The Supplement also gives information concerning registration, transportation, and other facilities. Attention is called to the desirability of making early table reservations for the President's dinner, to be held on Tuesday evening. Finally, some words of advice are submitted for those who wish accommodations at the Hotel Huntington, they being requested to make their reservations at once, and secondly, for members of the House of Delegates, who are urged to finish dining before 8 p. m., the hour scheduled for calling the House to order on Monday and Wednesday evenings.

And last, but not least, you are requested not only to consider possible attendance at the 1938 annual session, but actually to be among those present to profit and enjoy the meetings. If you do so, you will have no reason for regrets.

KERN COUNTY HOSPITAL APPELLATE COURT DECISION: SOME LEGAL INTERPRETATIONS

Full Text of Kern County Hospital Decision Was Printed in the February Issue.—Every case that is presented to a court of law, with attorneys representing opposing sides, naturally implies a difference of opinion, either by the parties in interest or by their legal advisers. The Kern County Hospital case—the full text of which opinion (as handed down by the Fourth Appellate District of California) was printed on page 106 of the February, 1938 issue of California and Western Medicine—was no exception to this rule.

* * *

Misinterpretation of the Kern County Appellate Court Opinion.—With that opinion, as embodied in the injunction provisions, under its Subdivision 8, we have no quarrel. But with those officials of Los Angeles County, who in direct or indirect administration of that county's public institution for the sick—the Los Angeles County General Hospital—have claimed that this decision of the Appellate Court not only gave them the right, but made it mandatory for them to send bills for hospitalization services, we have and continue to take issue. It has been our opinion, and still is, and in preceding months we have so stated, that the Board of Supervisors of Los Angeles County have been erroneously advised concerning the Kern County Hospital decision, both as to its context and as to its applicability to the Los Angeles County General Hospital.

* * *

Contradictory Statements by Los Angeles County Officials.—Just who were or who are the parties responsible for this faulty advice, legal and otherwise, we do not know, nor have we been able to find out. The officials themselves do not seem to know, because the Superintendent of the County Hospital, Mr. E. J. Gray, in his letter of November 3, 1937, stated:

> The Kern County decision requires that the charges billed to patients . . .

And again:

> In billing under the Kern County decision . . . (see February California and Western Medicine, page 99);

whereas Mr. J. C. Greer, Director of Accounts and Statistics, in a letter dated December 2, 1937,

in reply to a letter mailed to him on November 10, 1937, stated:

The basis for claiming reimbursement from a county client is found in the previously cited section of the Welfare and Institutions Code, not in the Kern County decision. . . . (See February CALIFORNIA AND WESTERN MEDICINE, page 104.)

* * *

Legal Opinions Opposed to Los Angeles County Interpretations.—Again, at a conference held in the office of the Board of Supervisors on February 12, 1938, the first of five questions or topics* on which an opinion was rendered by County of Los Angeles officials (legal and hospital authorities) was as follows:

"The Appellate Court decision in the *Goodall* vs. *Brite* case in Kern County, defining the County's responsibility relative to the operation of county hospitals and the fixing and collecting of fees."

The statements then made by representatives of the County were out of line with Subdivision 8 of the Appellate Court decision, already referred to above.

At that conference, Mr. Howard Burrel, counsel for the Association of California Hospitals, in a written opinion there submitted to Supervisor G. L. McDonough, stated:

In regard to indigents [indigent patients] having no present property, we find no requirement in the statute that they should be billed. . . .

In a letter dated January 19, 1938, Hartley F. Peart, Esq., General Counsel of the California Medical Association, gave the following opinion:

The injunction in *Goodall* vs. *Brite,* which was very carefully prepared and which was approved by the District Court of Appeal after a lengthy and exhaustive hearing, leads one to believe that the District Court of Appeal assumed that persons admitted to county hospitals as indigent sick or dependent poor persons, *after due inquiry and investigation had established such to be the fact,* would never be called upon to pay the cost of hospitalization if they should in the future acquire resources. . . .

Also, Mr. Peart added,

if the court's decision is not followed, and no injury and investigation is made, the answer is, of course, that the board of supervisors must be considered to be acting in excess of its statutory authority.

Read also what another able member of the legal profession wrote concerning the Appellate Court opinion, as follows:

Certainly, nothing in the judgment of the court even suggests to a reasonable person any obligation on the part of the defendants to collect from indigent persons or dependent or partially dependent persons, anything whatsoever.

This legal friend continues:

. . . The court does not say power to compel payment, but power to provide for hospitalization of each individual patient should be "charged to the patient on his ability to pay." It clearly implies that if a patient has no ability to pay, nothing should be charged to him; that if he is able to pay, say $1 or so a week, only that amount should be charged to him and to the extent that such a patient is able to pay only less than the entire cost of hospitalization in his own particular case, the Board of Supervisors should in their rules of admission provide for payment of the balance. Of course, here I come back to a clause that I have stated above, which makes this reasoning dependent on the legal authority of the Board to use public funds to pay the cost of hospitalization of totally indigent persons and the balance of the cost of hospitalization of persons able to pay only in part for the services rendered. Such authority seems to be clearly implied in the opinion of the court. . . .

. . . The fact that they have elected to charge persons for services amounts that they knew such persons would never be able to pay, and the fact that they have under the pretended cover of a court order spent public money in efforts to collect accounts which they knew were uncollectible, without asking further instructions from the court, would seem to me, in view of the clarity of the court's decision and judgment, to come very near to exposing them to punishment for contempt of court.

* * *

General Counsel Peart's Discussion in This Issue.—Elsewhere in this number of CALIFORNIA AND WESTERN MEDICINE, on page 297, in the standing Medical Jurisprudence department, Mr. Peart, General Counsel of the California Medical Association, discusses legal phases of the Appellate Court decision in considerable detail. Mr. Peart's opinion, which is worthy of careful reading by every member of the California Medical Association, has especial value, not only because in his many years of service with the California Medical Association he has had occasion to give particular attention to the matters at issue, but also because, in the appeal to Appellate Court in the Kern County case, he appeared as one of the attorneys for the respondents, as did also Mr. Burrell, whose opinion was also quoted above. (See February issue, page 107.) It is fair to assume, therefore, that they know somewhat of the legal matters under discussion.

* * *

Evasion of These Fundamental Issues Will Be of No Avail.—Our reason for giving space to the above is that some newspaper articles containing interviews with county officials seem to avoid the basic matters involved in the criticisms of procedures in vogue at the Los Angeles County Hospital, while what one might term an almost studious attempt to show the costs to taxpayers if patients are not billed, is seemingly emphasized.

No such evasion or begging the question will suffice in the matters at issue, which must be settled on the basis of California law and fair play alike to patients, taxpayers, and the medical profession.

* * *

Evidence in February, March and April Issues Is Convincing.—The evidence presented in the February, March, and April issues of CALIFORNIA AND WESTERN MEDICINE possesses sufficient merit to warrant an impartial and thorough investigation, in order that illegal and improper procedures may be stopped. That is a responsibility which the Board of Supervisors must meet, even though the duty be unpleasant. The medical profession asks for no favors for its members, but feels that the past and present services of physicians who are on the attending staff of the institution warrant that much, no matter what the ultimate decision may be.

* See March CALIFORNIA AND WESTERN MEDICINE, page 217.

JOINT MEETINGS WITH THE LEGAL, DENTAL, AND PHARMACEUTICAL PROFESSIONS

A Joint Meeting Held Twenty-five Years Ago.—In the Twenty-five Years Ago department of this issue, the first item, taken from comments by Editor Jones in the official journal of April, 1913, concerned a joint meeting of the Monterey County Medical Society and the Monterey County Bar Association:

Why Not More Such Meetings?—On February 22 there was held, at Del Monte, the annual gathering of the Monterey County Medical Society and the Monterey County Bar Association. It was a good meeting, a good banquet, and a very good idea inspired it; anything that will get doctors to mix with other professions is unqualifiedly good.

In a number of counties there are good, live medical societies and bar associations; why not steal this idea from Monterey and get together once a year for a joint session of well-mixed wit and wisdom? Surely, we can each learn something from the other, even if it is only the fact that the other fellow is not so bad after all!

Since 1913 a number of such meetings have been held in California. The attention of the Program Committees of county societies is called thereto because such gatherings should be held not only here and there, and then only at spasmodic intervals, but rather, as a regular annual routine and not by one, but by each of the component county medical societies that constitute the California Medical Association.

* * *

Meeting of Los Angeles County Medical and Pharmaceutical Associations.—The Los Angeles County Medical Association, for example, on March 17, in its headquarters' auditorium, held such a joint meeting with the members of the pharmaceutical profession, that meeting to be followed in April by a joint gathering with the County Dental Society, and in May with the County Bar Association. The attendance at the first of these three joint conferences was excellent, the inspiriting program including the following:

PROGRAM

Humane Pound Law in Its Relation to Research in Medicine and Pharmacology.

(*a*) From the standpoint of the pharmacist—Hon. James Boyle, Assemblyman, Sixty-sixth District.

(*b*) From the standpoint of the physician—Dr. Clinton H. Thienes, Department of Pharmacology, University of Southern California.

Federal and State Narcotic Laws.

(*a*) Cautions from the standpoint of the pharmacist—Frank Homer, President, Southern California Retail Druggists' Association.

(*b*) Cautions from the standpoint of the physician—Dr. William R. Molony, Sr., President, State Board of Medical Examiners.

Prospective Legislation of Interest to Medicine and Pharmacy—Mr. Frank E. Mortensen, Secretary, Southern California Retail Druggists' Association; Dr. E. T. Remmen, member of the California Medical Association Committee on Public Policy.

* * *

High Points in the Recent Los Angeles Joint Session.—The short and to-the-point papers given in the program quoted above were of such merit that they are reprinted on pages 257 and 258 of the current issue. It was particularly interesting to hear from Pharmacist James Boyle—who during several terms has been a member of the Assembly of the California Legislature, and has been such a staunch and able friend in all public health matters—his reaction to the "State Humane Pound Law," as based on actual experience with the forbears of the present proposed Initiative Act, when these bills came before the last several legislatures. It is to be hoped that members of the Association will take the time to read what Mr. Boyle and Doctor Thienes had to say on medical research work, and how proposed laws would greatly handicap such studies.

Of almost equal interest were the talks on the Federal Harrison Narcotic Act and the California Narcotic laws. These also are printed in this number, on pages 261 and 262.

* * *

This Year: Important to Public Health Interests.—Druggist Frank E. Mortensen has represented the pharmaceutical profession during the last several years at Sacramento, when the legislature has been in session. His recital of experiences was both instructive and interesting, and emphasized the comments by Dr. E. T. Remmen, member of the California Medical Association Committee on Public Policy and Legislation, on the need of special alertness in this state election year, and particularly so before and at the primary elections.

Component county societies are again reminded that the kind of legislation affecting public health standards and medical practice will depend in good part upon the character of the Assemblymen and Senators who will gather at Sacramento in January, 1939. Also, that every legitimate effort should be made in every one of California's counties to support only those candidates to Assembly and Senate whose past careers and records indicate a broad and fair outlook on all legislation related to the public health.

* * *

Time Allotments and Topics in Joint Meetings.—The general nature and time allotments of this year's program plans of the Los Angeles County Medical Association were outlined on page 231 in the March, 1938, issue of CALIFORNIA AND WESTERN MEDICINE, and the attention of program committeemen who failed to note the item is directed anew for such suggestive value as it may have for other county units.

CALIFORNIA MEDICAL ECONOMIC SURVEY

A Recent Review in the "Journal of the American Medical Association."—On page 289 appears an article, "California Medical Economic Survey," reprinted from the February issue of the *Journal of the American Medical Association*, in which some frank comments are made on the "Report on Factual Data" of that survey, as brought off the press by the California Medical Associ-

ation in November last, a copy having been sent at that time to each member of the California Medical Association.

* * *

"Journal of the American Medical Association" Criticisms of Deficiencies in Survey Directors' Tables.—The *Journal of the American Medical Association* criticisms call particular attention to the somewhat loose manner in which the director of the survey used the terms "adequate" and "inadequate" in compiling his tables. Exception is also taken with the phrases and comment dealing, "With regard to standards or definitions of illness and diagnosis" and "On the subject of medical treatment." Quoting further:

> There is a tendency throughout the published tables to exaggerate the lack of medical care, the cost of such services, and the implied defects of the medical profession, by the arrangement of the tables and the wording of the captions. . . .
>
> The Census Bureau of the United States Department of Commerce issues periodic estimates of the population of the states, but there appears no explanation of the use of a local estimate in preference to the Census Bureau estimate of the population. Likewise, the number of physicians in California in 1934 is less by 1,407 than the number given in the 1934 American Medical Directory. . . .
>
> If Figure 16 is used to represent the prevalence rate of specific disease, California is depicted as a very unhealthful place in which to live. . . .
>
> These complete figures for all the recorded physicians in California were available at the time the California Medical Economic Survey was conducted. The California survey figures give a grossly distorted picture of the percentage of general practitioners and specialists in that state. . . .
>
> The tables and figures in this report give the reader the impression that there has been an effort to arrange a build-up for sickness insurance. . . .

* * *

Survey Project Has Been Completed.—In these columns in former issues of California and Western Medicine, in order to avoid controversy, nothing more has been sought other than to place on printed record, in the Official Journal of the California Medical Association, the informative facts that this FERA-WPA project had been completed to the satisfaction of the Federal authorities, and that the final report as submitted by the survey director was the property of the State of California, to be used or reprinted only in such manner as the constituted State agency appointed by the Federal authorities—in this instance the California State Board of Public Health—deemed proper. It is gratifying to know that the Council of the Association will be in a position to report to the House of Delegates in May that this survey adventure, which was begun in 1934, is finally a completed task.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 274.

EDITORIAL COMMENT†

THE TREATMENT OF CHRONIC OCCLUSIVE PERIPHERAL ARTERIAL DISEASE

The sufferer from chronic peripheral occlusive arterial disease presents a problem which has only recently received the more serious attention of the profession. These affections take a heavy yearly toll in incapacity, suffering, loss of limb and, much too often, loss of life. It is imperative, therefore, that the sufferer be given every chance to preserve the integrity of his extremities and the loss of his activity.

The first duty of the physician is to establish, if possible, the nature of the effection. The vascular diagnostician must be fully conversant with the anatomy and physiology of the peripheral circulation, and the relationship of the autonomic nervous system to it. To the general examination, and examination of the vascular competency of the extremity, must be added an estimation of the part played by the sympathetic nervous system in the disability. This estimation of arterioconstriction should be quantitatively determined by utilizing an accepted method of vasomotor study. The treatment of the individual case will depend in a great measure upon the available vasodilatation.

The occlusion at hand may be due to arteriosclerosis, thrombo-angiitis obliterans, endarteritis obliterans, and other more rare affections. Whatever the nature of the occlusion, it is manifested by decreased flow of blood to the part; whatever its nature, the treatment aims to increase the circulation to the impoverished extremity. In many of these affections arteriospasm is an important factor in the early stages; by diminishing the blood supply and retarding the flow, it may be partially responsible for the onset of thrombosis and eventual tissue death.

If there is little or no vasoconstrictor element, it is illogical to consider an attack directed toward ablation of sympathetic influence. The usual conservative treatment must not be neglected. Suction-pressure therapy may be beneficial in some cases; in many it is of no avail.

Ligation of the main vein to the extremity may be considered in a small group of carefully-selected cases; despite opinions advising against this procedure, the writer has noted gratifying results in a small number of cases so treated. Drugs have been, without exception, disappointing.

When the element of vasoconstriction is considerable, the treatment is best directed toward releasing this factor. Diathermy, the administration of vasodilating drugs by iontophoresis and otherwise, suction-pressure therapy, artificial fever, and other methods have frequently given but temporary relief. Ganglionectomy will, without doubt, increase the total blood flow to the part by an amount equal to or greater than that indicated by preoperative vasomotor studies. Following opera-

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

tion the increased blood flow will be present day and night, and will be more marked and far more persistent than that obtained by any other means known to the writer. It may be the important factor in establishing a satisfactory collateral circulation to a failing extremity which might otherwise soon progress to ulceration or gangrene. It should be done early, before the vasoconstrictor element has decreased with the progress of the disease. The writer performed lumbar ganglionectomy on such a patient four years ago, the temperature of whose desympathectomized extremities is still maintained at the maximum level. Less satisfactory results are obtained in the upper extremities. The operation requires only about one week hospitalization and carries, in trained hands, practically no mortality. Although the circulation can thus be unequivocally increased, only about half the number of patients are relieved of severe claudication; yet the operation gives them more insurance against the serious complications of the disease than any other procedure.

450 Sutter Street. Felix L. Pearl,
San Francisco.

STRABISMUS IN CHILDREN

Dr. S. A. Durr's paper,[1] read by him before the Eye Section of the California State Medical Association in 1936, again draws our attention to the problem of strabismus in children.

Samuel Butler, in Erewhon, described a civilization where medical knowledge is so advanced that sickness is a crime. When people are sick, instead of sending them to a hospital, they are sent to jail, because there is no excuse for ill health. The time will come when somebody will be imprisoned whenever there is a child who has strabismus. Whether the parents or the attending ophthalmologist will be incarcerated in the Bastille for such a heinous crime as the neglect of a child with strabismus, remains to be seen. Probably both the parents and the attending ophthalmologist will be condemned.

The reduction of the number of children seen with strabismus is best illustrated in the case of the school children of San Francisco. In 1929 I reported the summary of eye examinations, personally conducted, of over fifteen thousand children.[2] The number of children found with uncorrected strabismus of varying degrees was 2.4 per cent. Since that time the number of children with strabismus seen in the schools of San Francisco has been greatly reduced. It is now possible to examine the children in a large school and not find one uncorrected case of strabismus. It is my impression that the number of children with strabismus in San Francisco is now less than one per cent.

This has been accomplished through two factors:

1. The education of the school teachers and the follow-up work by the nurses of the San Francisco Department of Public Health of all cross-eyed children. Through them the parents have been educated to the necessity of early medical attention, which a child with strabismus needs. Indirectly the medical profession, especially the pediatrician, has become aware of the fact that children do not "outgrow a squint." The school nurse and the physician realize that if glasses do not promptly correct a squint, operation is indicated, and the age of the child is no contraindication to an eye operation.

2. The popularization of O'Connor's operation for squint makes it possible to operate on a child at any age. Doctor Durr has fully covered the advantages of O'Connor's operation. From the parents' point of view—and after all it is the parents who have to be persuaded as to the necessity of the operation—the fact that hospitalization can be reduced, if necessary, to only twenty-four hours, is one of the most important factors in obtaining permission to operate early on young children. Although I am not so old, I can still remember the time when, after doing an advancement, it was necessary to cover both eyes, use a starch bandage, and keep the child from ten to fourteen days in the hospital. The average age of the last forty strabismus cases operated on at the Stanford University Eye Clinic, with the O'Connor method, was nine and one-half years. Ten years ago the average age of a child operated on for a squint was around fourteen years. It is not necessary for me to emphasize the importance of early operative procedure in squint cases.

Doctor Durr's paper is of great importance in that it again draws the attention of the medical profession to the advantages of the O'Connor operation and its importance in the reduction of the number of uncorrected cases of strabismus.

490 Post Street. Frank H. Rodin,
San Francisco.

CREEPING ANOXEMIA IN BRONCHOPNEUMONIA

A positive correlation has been noted by Stadie, Binger, Barach, Hill, Campbell, Poulton, and other investigators, between anoxemia and mortality in pneumonia. If anoxia is a contributory cause of death, it is so by its action on the vital centers—particularly myocardium, medullary and other nerve centers. The nervous system being particularly sensitive to oxygen want, symptoms usually appear when the oxygen unsaturation of the arterial blood drops to 15 per cent.

Evidence of anoxemia, manifested either by diffuse cyanosis, characterized by leaden pallor of the face or by nondiffuse cyanosis with bluish tint of fingernails, chin, lips, ear, cheek, may be apparent so late that valuable time has been lost before oxygen therapy becomes available.

Stadie has shown that O_2 unsaturation of the arterial blood, over 30 per cent, generally results fatally. A higher degree of unsaturation occurs in bronchopneumonia than in the lobar type.

In some of the bronchopneumonia patients in the recent epidemic, symptoms referable to the nervous system included: restlessness, sleeplessness, talkativeness, apprehension, and increased

1 O'Connor Cinch-Operation Technique, *American Journal of Ophthalmology*, Vol. 20, pp. 178-180, February, 1937.
2 Eye Examination of School Children, *Journal of the American Medical Association*, Vol. 93, pp. 911-916, September 21, 1929.

nervous tension, with spasticity of the voluntary muscles. The mind may be lucid, mental impressions being clear-cut and accompanied by actual euphoria. Tingling and hypoesthesia in the extremities were often pronounced, and should the anoxia continue unrelieved, are replaced by numbness and marked muscular weakness.

In adults the onset of either periodic, or shallow and rapid breathing is ominous. When there is no retention of CO_2 in the body, however, the patient may feel no distress and make no complaint, although in great danger from acute oxygen want. Because of the insidious development of the condition described, the term "creeping" anoxemia has been chosen.

Attempts to control the above symptoms by administration of barbiturates or opiates are contraindicated, as they tend to increase respiratory depression and the degree of anoxemia.

Although only a supportive measure in the management of the bronchopneumonia patient, on the other hand, early oxygen inhalation is invaluable.

Boothby's observation of a drop in temperature following a patient's admission to the oxygen chamber has been confirmed. It is noteworthy that, although oxygen often relieves restlessness, it may occasionally increase the restlessness of a patient, owing to recovery of the higher centers. To avoid this, the percentage of oxygen should be raised slowly, *e. g.,* from 3 to 6 liters per minute in one hour.

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HEMORRHAGE AND SHOCK INCIDENT TO CESAREAN SECTION

Cesarean section is in great part responsible for the prevalence of a high maternal mortality in this country. The triumphs of modern surgery, and particularly the safety and success of the present-day laparotomy, have given the profession, as well as the laity, a false sense of security so far as cesarean section is concerned. It is not fully realized that cesarean section carries the risks of laparotomy in general, plus the hazards of a most unphysiologic method of delivery.

The dangers of hemorrhage, shock and infection, which are common to most laparotomies, are multiplied manifold in the case of abdominal delivery. In a recent review of nine hundred cesarean sections performed in Iowa, Plass[1] found that the maternal mortality was 7 per cent. Forty-nine and three-tenths per cent of these deaths were due to sepsis, 19 per cent to toxemia, and 20.7 per cent to hemorrhage and shock. Hemorrhage, also, undoubtedly plays an important part as a cause of death in the fatalities ordinarily attributed to toxemia. Dieckmann and Daily[2] recently made accurate measurements of the blood loss incident to cesarean section at the Chicago Lying-In Hospital. They found that the quantity of blood lost ranged between 170 cubic centimeters and 1,410 cubic centimeters, the average being 546.7 cubic centimeters. In the hands of the occasional operator, this blood loss must, of course, be much greater.

Hemorrhage in cesarean section is undoubtedly due to the disturbance of the physiology of labor. It is a well-known fact that the uterine muscle is relatively insensitive to stimulation until the end of pregnancy. With the onset of labor there is an abrupt rise in the susceptibility of the uterus to mechanical stimuli, and to the influence of oxytocic drugs; this irritability increases during the progress of labor, and reaches its height during the course of the second stage. It seems, then, that it is distinctly unphysiologic to precipitate the third stage of labor on a uterine muscle which is unprepared even for the first stage. Hemorrhage, consequently, is to be expected when labor is eliminated, or terminated early in its course.

The above remarks are not presented as an argument in favor of cesarean section late in labor. It is, however, intended to point out that the wisdom of elective cesarean section is open to question, and that the burden of proof must be assumed by those who maintain that the best results are obtained when cesarean section is done at an "appointed time," rather than at the onset of labor.

The abrupt termination of the third stage is another radical departure from the normal. The incision in the uterus frequently encroaches on the placental site, especially in the classical section. It is, therefore, necessary to remove the placenta promptly in an effort to control the profuse bleeding from the incision, and from the coincident partial detachment of the placenta. This interference with the natural course of the third stage tends to cause hemorrhage in cesarean section, just as it does in vaginal delivery.

Shock in cesarean section is chiefly due to the following factors: general anesthesia, celiotomy, the sudden release of the amniotic fluid, the immediate delivery of the fetus and placenta, and the coincident unavoidable hemorrhage. Commonly associated obstetrical factors which further predispose to shock are exhaustion from prolonged labor, toxemia, antepartum hemorrhage, and overdistention of the uterus due to multiple pregnancy or polyhydramnios.

The foregoing review emphasizes the facts that cesarean section is often complicated by serious hemorrhage and shock, and that the hazard due to these complications can be lessened by a careful selection of cases for section, and by a close adherence to well-established obstetrical and surgical principles. Abdominal delivery is, however, fundamentally an unphysiologic procedure, and no care and skill in its performance can fully compensate for the profound disturbance created in the mechanism of labor. Hemorrhage and shock, therefore, should be anticipated in all cases of cesarean section, and adequate preparations be made to meet these emergencies before surgery is undertaken.

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SAMUEL HANSON,
Stockton.

1 Plass, E. D.: Survey of Cesarean Sections in Iowa for Years 1930, 1931, and 1932, Preliminary Report, J. Iowa M. Soc., 25:586 (Nov.), 1935.

2 Dieckmann, William J., and Daily, Edwin F.: Blood Loss During Cesarean Section, Am. J. Obst. and Gynec., 30:221 (Aug.), 1935.

ORIGINAL ARTICLES

HYPERPARATHYROIDISM: WITH SPECIAL REFERENCE TO PARATHYROID ADENOMA*

By William W. Washburn, M.D.
San Francisco

Discussion *by H. Lisser, M. D., San Francisco; Paul Michael, M. D., Oakland; Robertson Ward, M.D., San Francisco.*

CLINICALLY, hyperparathyroidism manifests itself in the presence of (1) parathyroid adenoma, or (2) generalized hyperplasia of the parathyroid bodies. Although a hypertrophy and hyperplasia of the parathyroid bodies may be found in conditions such as osteomalacia, osteitis deformans, multiple myeloma, metastatic carcinoma, rickets, scleroderma and nephritis, the enlargement in these conditions is of a secondary or compensatory nature. The principal condition in which hyperparathyroidism is noted is due to adenoma of the parathyroids, and gives rise to the disease described by von Recklinghausen in 1891. He outlined certain changes in the skeleton, to which he applied the term "osteoitis fibrosa." In 1925, Mandl [1] noted improvement in a case of osteitis fibrosa following the removal of a parathyroid tumor, and to him is usually given the credit for establishing a distinct relationship between the two conditions. However, Schlagenhaufer,[2] in 1915, demonstrated two autopsy specimens with enlarged parathyroid glands and marked skeletal changes. He stated that he believed that surgical removal of the tumor was indicated in advanced cases of bone change. Since that time numerous observers have contributed to our knowledge of the disorder. In 1930, Du Bois,[3] in the United States, published a case of osteitis fibrosa cystica associated with hyperactivity of the parathyroid bodies. The term "hyperparathyroidism" was first used in 1929 by Barr,[4] who reported the first proved case in the United States. Due to the increased interest in study of the parathyroids during the last decade, the number of reported cases has gradually been increased, though still comparatively small, as will be noted from the report of Wilder and Howell [5] as late as 1936. From their review of the literature, they were willing to accept 135 cases reported in the eleven years intervening since Mandl's publication. At the time of this publication, these authors had found but five proved cases from the Mayo Clinic, one of which was operated by Rankin in 1929, and which case was one of the first operations successfully performed for this condition in the United States. These authors note the relative scarcity of cases reported from different parts of this country, although surgeons may be alert to the condition. Barr has reported but four proved cases. The most remarkable series of cases has been those thirty-five or more cases reported by Churchill in Boston. Goldman and Smyth,[6] at the University of California, reported their two proved cases.

MAIN FEATURE OF HYPERPARATHYROIDISM

The main feature of hyperparathyroidism is a disturbance in the calcium and phosphorus metabolism, as evidenced by an increase in serum calcium, a decrease in serum phosphorus and an increased excretion of both of these elements in the urine. As a result of this excessive secretion of parathyroid hormone, characteristic changes take place, in most instances, in the bones. Inasmuch as the bones are the only storehouses of calcium and phosphorus in the body, this supply may become mobilized in a more or less rapid manner, according to the severity of the disease. In more or less early cases, upon x-ray examination there may be pronounced demineralization, whereas in the more advanced cases there are large irregular areas noted due to cystic formation (osteitis fibrosis cystica). In some instances there may be change in posture with rather marked kyphosis of the spine; bowing of the long bones and spontaneous fractures frequently occur.

Although the skeletal changes incident to hyperparathyroidism may be disabling, the real hazard of the disease is in the damage suffered by the kidneys, and it is noted that death, in most instances, is due to renal insufficiency or to complications of kidney stones. The patient usually shows rather marked loss of weight and loss of strength, and there is frequently a complaint of pain in the back, especially pronounced after exercising. There may also be generalized bony tenderness, especially in cystic areas—von Recklinghausen's disease.

If, at operation, one fails to find a tumor in the face of a well-established case of hyperparathyroidism, it may be possible that one is dealing with a generalized hyperplasia of all of the parathyroid bodies, a condition analogous to so-called Graves's disease of the thyroid. Though doubtful of the existence of such a condition at first, Bauer,[7] Churchill and Cope,[8] Castleman and Mallory,[9] and Albright [10] now recognize the condition of generalized hyperplasia of these bodies. This latter writer has reported several cases of patients with renal calculi which, when operated upon, showed enlarged hyperplastic parathyroid glands. These patients presented no skeletal changes or elevation of plasma phosphatase, but did show high serum calcium and low serum phosphorus readings. These patients were relieved by resection of approximately three-quarters of the total parathyroid tissue identified at operation.

REPORTS OF CASES

Case 1.—Von Recklinghausen's disease due to parathyroid adenoma. Patient: J. B., male, age forty-four. Employed for seventeen years by the Southern Pacific Company. Married. Born in Nebraska. Has lived in Colorado, Oregon, and Idaho. For the past eight years he has been living in Los Angeles.

Family History.—Negative. No history of any familial disease, nor had he any relatives that he knows of who ever suffered from any bone or joint disorders. The patient had had no previous operations. No accidents, injuries, nor broken bones. No previous hospital entrances during the past seventeen years of service.

* Read before the General Surgery Section of the California Medical Association at the sixty-fourth annual session, Del Monte, May 3–6, 1937.



Fig. 1.—X-ray, showing multiple kidney stones.

Present Illness.—States that he was perfectly well, as far as he knows, until approximately two years ago, at which time he first experienced some urinary frequency, polyuria, and pain in the low back region. There had been occasional attacks of abdominal pain associated with distention and passing of cloudy urine. During the past year or more he says that he passed gravel on some occasions, and states that the pain in the low back region was markedly aggravated by exertion. For the past few months he has experienced some dull aching pain, especially in the "shin bone." There has been a progressive sense of fatigue and muscular weakness more pronounced the last six months. His weight, which two years ago was 170 pounds, on entry to the hospital gradually has fallen to 135 pounds. Has noticed no change in his height, which has been 5 feet 9 inches for some years. Noticed no change in posture. He has not been constipated and uses no cathartics. The patient was admitted to genito-urinary service of the General Hospital on February 27, 1935, with diagnosis of renal calculi.

Physical Examination. — Showed fairly well-developed and well-nourished man, who looked to be about the stated age.

Head: Essentially negative, except for *slight swelling of the left jaw* in the temperomandibular region. Slightly tender on palpation. Opens and closes jaw fully. No remarkable infection about the mouth.

Heart and lungs: Negative.

Neck: There is moderate enlargement noted for both lobes of the thyroid, which gives the impression of containing adenoma of both lobes (thyroid adenoma).

Blood pressure: Normal, 140 systolic and 88 diastolic.

Back: Essentially negative. There was no pain noted on pressure over any of the bones, except along the crest of both tibiae, where the patient states there was some tenderness.

The abdomen: Is negative. There is no remarkable tenderness on palpation over both kidney regions. Liver and spleen were not enlarged to percussion and palpation.

Reflexes: Normal.

Laboratory Data.—X-rays of kidneys showed multiple stones in both kidneys, together with one stone in the left ureter, producing marked obstruction with dilatation of ureter (this stone was removed by simple dilatation). X-rays of skeletal system showed the following: Marked



Fig. 2.—Note x-ray appearance of cyst of inferior maxilla. Similar cystic areas were noted in the ribs and fibula.

demineralization of the skull and femur bones, cystic changes in the left jaw bone, multiple cysts and healed pathological fractures of one of the ribs on left side (in going back over the history, the patient stated that he had had a mild attack of "pleurisy" in this area three months prior to entry to the hospital relieved after two weeks by strapping). Left fibula showed cystic changes in the central portion of the shaft. Blood studies showed marked elevation of urea and nonprotein nitrogen. The urea nitrogen ranged from 38.4 to 26.4. The blood Wassermann test, reported positive upon entry was found subsequently to be negative.

Blood serum calcium was elevated to 19.3, and serum phosphorus was down to 2.9. Subsequent readings showed consistent high calcium and low phosphorus readings.

On the basis of the x-ray findings, together with laboratory findings of high calcium and low phosphorus reading, a preoperative diagnosis of parathyroid adenoma was made.

* * *

Case 2.—B. M., female, age forty-four years. Born in Nebraska. Moved to Oakland at age of four years and has lived in Oakland since that time, except for eight months in Seattle at age of twelve.

History.—This patient gives history of having passed "gravel" in her urine for the past three years. She has had periods of chills and fever with passing of cloudy urine on numerous occasions. Considerable discomfort and lameness in low back region on exertion. Noted no change in posture. No tenderness over any of the bones. No other complaints except urinary frequency and passing of gravel. X-ray studies show multiple stones in both kidneys.

On March 21, 1937, blood serum phosphorus reading was 13.5, serum phosphorus reading 2.4. Nonprotein nitrogen, 33.3. Urea nitrogen, 13.2. The urine was loaded with pus cells and numerous red blood cells. On April 23, the blood serum calcium again showed a reading of 12.5, serum phosphorus reading 2.6.

X-rays of the spine, skull, ribs, femur and tibia bones, showed no evidence whatsoever of decalcification or cyst formation.

Comment.—This patient has left the hospital to return in the next few days, when further investigation of her genito-urinary system will be made. It is felt, however, that this case may possibly be one of that rarity as reported by Albright,[10] namely, of renal calculi associated with high serum calcium, low serum phosphorus readings, with an absence of any skeletal changes as noted in the x-rays, but with multiple renal calculi. I feel that if further studies continue to show similar condition, operation is indicated for hyperparathyroid condition



Fig. 3.—Drawing made at time of operation. Note nodular appearance of both lobes of thyroid, which contained multiple thyroid adenomas as well as parathyroid adenomas.

due most likely to generalized hyperplasia of the parathyroids.

SURGICAL CONSIDERATIONS

Operation for hyperparathyroids should not be performed unless a definite preoperative diagnosis has been made. From the review of the literature and from my experience in the case presented herewith, it is apparent that technical difficulties are not infrequently encountered. It would seem superfluous to mention that the operating surgeon should be thoroughly familiar with surgical procedures on the thyroid gland itself. Furthermore, he should be familiar with the anatomy of the parathyroid bodies, and especially be mindful that they may be found in atypical locations.

It has been pointed out that atypical location of these bodies is not infrequently encountered, as emphasized by MacCallum [11] in 1906, and Halstead and Everett in 1907, as well as by Terry and Millzner [12] in 1927. These authors have shown that in 30 per cent of a series of their operative cases, one or more glands were found to be present on the lateral aspect of the thyroid, while in 10 per cent of their cases one or more glands were found to be present on the anterior surface of the gland.

As emphasized by Churchill and others, a parathyroid tumor is often found well concealed in the recess between the trachea and esophagus, or laterally about or outside of the capsule and areolar tissues surrounding the lateral lobes of the thyroid.

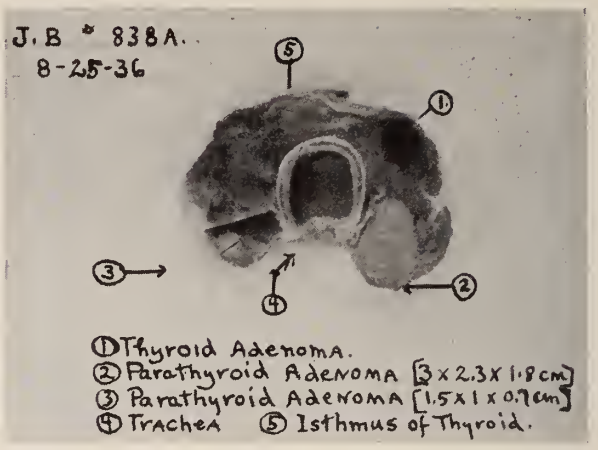


Fig. 4.—Cross section from postmortem examination. Note two remaining parathyroid adenomas buried beneath thyroid gland.

One must be prepared to extend the search deep into the mediastinum (as in the case reported by Churchill,[13]) or in some instances the tumor may be within the lobes of the thyroid gland (as noted by Lahey.[14]). It should be borne in mind that multiple tumors may be present (as noted in my own case). The presence of multiple tumors presents a serious consideration, and may call for secondary operation or partial resection on account of the danger of severe postoperative tetany due to the rapid lowering of blood calcium immediately following operation. Symptoms of tetany usually ensue from removal of a single parathyrloid adenoma.

If one fails to find a tumor or definite hyperplasia of all of the parathyroids at operation, normal glands should not be removed in an effort to reduce hyperparathyroidism, as emphasized by Churchill.[13] There is no known indication for removal of a normal parathyroid body. Such a procedure is futile and may present serious results at a later date, should the tumor be found and removed. Churchill reports a case in which normal glands had been removed at previous operation, the parathyroid tumor finally being found in the superior mediastinum and removed at secondary operation. Severe tetany ensued and the patient died.

DISCUSSION OF A CASE REPORTED

In the proved case herewith presented, a preoperative diagnosis of parathyroid adenoma was made. At operation the usual Kocher collar incision was made, as for thyroidectomy. The prethyroid muscles were divided transversally and retracted. Both lobes of the thyroid were found to be considerably enlarged and contained numerous small adenomas (see figures). A careful preliminary search about both lobes of the thyroid gland revealed no gross evidence of parathyroid tumor. By elevating the inferior pole of the thyroid on each side, and by careful exploration of the subclavicular and substernal regions, a mass was found which presented a smooth, rounded surface. It was discreet and freely movable. A definite vascular pedicle extended downward into what was apparently a parathyroid tumor in the sub-

clavicular region. When fully exposed, it was about 4 by 2 centimeters in size. It was yellowish-white and paler than the thyroid tissue, and lighter than the normal parathyroid. The tumor was removed with very little difficulty. Before closing, further search for other parathyroid bodies was made.

The pathological report by Dr. A. M. Moody showed parathyroid adenoma (benign). Weight 10.10 grams, size 3.8 by 2.5 by 1 centimeters.

Following operation, the patient was very carefully observed for any signs of tetany or parathyroid insufficiency. However, these signs failed to develop, and upon repeated examinations the patient showed no numbness or tingling of the extremities and a negative Trousseau and Chvostek sign. The day following operation the blood serum calcium reading was 16.1 milligrams, serum phosphorus 3.2 milligrams. Numerous determinations taken at frequent intervals continued to show high calcium and low phosphorus. While the serum calcium and phosphorus had not shown rapid changes, as was expected, it was felt at first that this might possibly be due (as pointed out by Albright and his associates) to the coexisting marked impairment of renal function. It was thought more likely that the patient still had other parathyroid tumors which had been overlooked at operation. Further surgery was deemed unwise at this time on account of the patient's advanced nephritis with kidney stones associated with fever and pyuria. X-ray treatment was instituted in the hope of diminishing the activity of any parathyroid bodies or tumors which might have remained following operation. Although a review of the literature discloses but few instances of the use of x-ray in the treatment of such a condition, Merritt and McPeak,[15] in 1934, reported what was apparently most satisfactory results from radiating the cervical region in six cases of cystic bone disease which, in their opinion, were due to hyperthyroidism. From my review of these cases it would appear that a definite tumor had not been proved by operation or necropsy. Furthermore, Aub, Albright, and Bauer[16] report one patient who had received massive doses of x-ray over the neck region before operation. They found no change in urinary excretion or blood calcium values, and the tumor removed at subsequent operation showed no definite changes whatsoever as the result of radiation. In the opinion of these authors there is no successful treatment of this condition other than surgery. However, our patient was given the advantage of any possible benefit by routine type of radiation, such as is used occasionally in hyperthyroidism; and there was no remarkable response to this treatment, and the blood serum calcium and phosphorus remained at the usual abnormal levels. The patient having been given leave of absence from the hospital at his own insistence, returned at a later date with severe kidney complications, from which he died. At autopsy it was of interest to note that the patient still had remaining two parathyroid adenomas, which were partially obscured by overlying thyroid tissue. The thyroid gland contained numerous adenomatous growths.

Histological examination of sections from these two tumors showed benign parathyroid adenomas. In comparing their histological appearance with that of the tumor removed at operation, Doctor Moody could note no remarkable changes as the result of x-ray therapy.

SUMMARY

1. Report of case of hyperparathyroidism, due to multiple parathyroid adenomas, is presented together with the clinical metabolic, and roentgenologic findings upon the basis of which a preoperative diagnosis was made.

2. With patients showing renal calculi or presenting clinical and x-ray findings of bony pathology simulating osteitis fibrosis cystica, a thorough investigation must be made, bearing in mind the possibility of hyperparathyroidism and parathyroid adenoma. By so doing, it is felt that many additional cases will be discovered which have heretofore been overlooked.

3. The treatment is essentially surgical. A definite diagnosis (based upon x-ray and blood chemistry findings) must be made before treatment is instituted.

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DISCUSSION

H. Lisser, M.D. (384 Post Street, San Francisco).—Doctor Washburn has done well to report his experience with two cases of hyperparathyroidism. It would be highly desirable, for a few years longer, if other clinicians did likewise, since our understanding of hyperparathyroid syndromes is relatively recent, and probably not yet complete. It is altogether likely that the condition in its various manifestations is somewhat uncommon, but probably by no means as rare as some would think. Therefore, the publication of as many verified cases as possible will serve the

significant purpose of focusing greater attention on this interesting and important endocrinopathy.

Individual narratives, or case reports, have their value and teach varying lessons. For example: the extraordinary story of the sea captain (Bauer's case), suffering from osteitis fibrosa cystica, who insisted on repeated explorations until, at the seventh operation, the substernal adenoma was finally located, is not only dramatic but illustrates the necessity for the most painstaking search for oddly located parathyroid tumors. Similarly, Doctor Washburn's extirpation of a typical adenoma, without relief of the hyperparathyroidism because more than one such adenoma was responsible, adds another instructive point to the factors which must be considered in the treatment of this condition.

The recognition of Von Recklinghausen's disease as a definite endocrine entity constitutes an illuminating illustration of the scientific progress to be accomplished by intelligent utilization of preclinical or experimental research in the interpretation of clinical disorders. It is quite true, as Doctor Washburn notes, that Mandl, in 1925, happened to be the first to note improvement in a case of osteitis fibrosa, following the removal of a parathyroid tumor, but he did not have the acumen to interpret his fortunate experience adequately. This needed, quite naturally, the important investigations of Collip (1926) (and Hansen, independently), who first isolated a potent extract of the parathyroid glands, and convincingly demonstrated its influence on calcium metabolism. They were able to relieve the hypocalcemia of tetany (hypoparathyroidism) by injections of this parathyroid hormone, and also produced hypercalcemia in the experimental animal by injecting large amounts of this extract. David Barr, professor of medicine at Washington University, St. Louis, deserves the distinction of having been the first to postulate the syndrome of hyperparathyroidism as the cause of osteitis fibrosa cystica (1929) and, by removal of a parathyroid adenoma, reverse a negative calcium balance to the normal positive ratio. The Boston group, Churchill, Bauer, Aub, and Albright, extended these observations bountifully, and they have had by far the largest series of cases reported anywhere in the world. Their extensive experience added the clinical picture of parathyroid hyperplasia as a cause of renal stone, and emphasized the seriousness of the resultant nephritis. This contribution is so important that no internist or urologist should be guilty of failing to determine the blood serum calcium in every instance of renal lithiasis.

It is rather diverting now, in retrospect, to recall some of the peculiar maladies, such as paralysis agitans, which, theoretically, were formerly ascribed to an excessive parathyroid function.

It was assumed that, since a state of nerve muscle agitation was the opposite of muscular spasm (tetany), and since the latter was due to deficient parathyroid function, the former might be explained by parathyroid overactivity. It is a far cry from such armchair speculation to the sound scientific explanation of the metabolic osseous malady, Von Recklinghausen's disease, first described in 1891, shrouded in mystery for over thirty years, yet now understood with perfect clarity. The hyperfunctioning parathyroid adenoma robs the skeletal storehouse of calcium, demineralizing it and leaving cysts, accumulating excessive amounts of calcium in the blood, with resultant clogging of the renal tubules and calyces, so that calcium stones are formed, which ultimately impair renal function. Removal of overactive parathyroid tissue restores a positive calcium balance and permits calcium to be redeposited in the bones.



Paul Michael, M.D. (434 Thirtieth Street, Oakland). Doctor Washburn, in his paper, has brought out many points which are of pertinent interest to all students of this condition. It is likely that in the past many of these parathyroid adenomata were classed in the group of Paget's disease, and hence were denied relief by surgical removal. Although still comparatively rare, the subject of parathyroid adenomata is gaining in medical importance, and many remarkable cures have been reported. The realization of the importance of blood phosphatase and magnesium has added a great deal to our diagnostic armamentarium. It would have been of great interest to have subjected Doctor Washburn's patient to a calcium balance test to ascertain the degree of calcium loss. The presence of such high serum calcium, however, was sufficient corroborative evidence for the diagnosis. Among other important things, Doctor Washburn's case proved several points, among them (1) that these parathyroid tumors are frequently multiple; (2) that they very often are associated with thyroid adenomata; and (3) that many of these tumors are first brought to the attention of the patient by passing kidney stones.

It should be emphasized that the thymus is very often associated with calcium metabolism, hence failure to find a parathyroid adenoma may justify radiation to the thymus region as a therapeutic test. It must be mentioned, also, that all cases of parathyroid adenomata are not associated with fibrocystic diseases of the bones. Two cases recently seen by me were characterized by a simple demineralization without cyst formation, yet both had large parathyroid adenomata.

Robertson Ward, M.D. (384 Post Street, San Francisco).—Doctor Washburn's proved case of parathyroid adenoma brings out a number of extremely interesting points in the diagnosis and treatment of parathyroidism.

The first of these is the possibility of multiple adenomata and their unexpected locations. If the tumor, or tumors, can be localized preoperatively, their removal is much simplified. The use of a thick barium meal and visualization by x-ray should not be neglected, as occasionally an indentation of the esophagus offers an exact localization. At operation a meticulous search of the entire neck and upper mediastinum is required, and this is especially true where preoperative localization has not been possible. The surgeon who attempts such an operation, besides being familiar with the thyroid surgery, should know how to recognize parathyroid tissue by its chocolate color, its smooth fragile texture and its difference in appearance from thyroid, lymph node, fat and thymus tissues. He must be familiar with all possible nooks and crannies, including the thyroid gland itself in which the tumors could be tucked away. In order to make an adequate exploration he must have good exposure and perfect hemostasis. Anyone who has explored the upper mediastinum knows how difficult the attainment of these requirements are. It must be realized that the first operation is the time to obtain a cure. The temptation to remove normal parathyroid tissue must be avoided at all costs, and this dictum presupposes a thorough knowledge of the normal and abnormal locations of these bodies.

The second point of interest in Doctor Washburn's experience is the absence of a prompt drop in serum calcium after operation and its implication that the offending tumor had not been removed. Wilder and Howell found a calcium drop of 3 milligrams per 100 cubic centimeters so uniformly after operation that, when such a change did not take place, it threw doubt on the diagnosis and therapy. It would appear that a drop below normal is not necessary either for the proof of effective therapy or for the appearance of postoperative tetany. One case has been reported of severe tetany with a serum calcium reading 9 milligrams per 100 cubic centimeters, the level having been 14 milligrams before operation.

The third point of special interest in this paper, it seems to me, is the demonstration of the complete inefficacy of x-ray or medical treatment in this disease. The absence of any significant change in the appearance of the irradiated parathyroid tumors from the one originally removed speaks eloquently in this respect. This, however, is what one would expect from experience in the effect of x-ray on other benign tumors. With regard to medical treatment, Albright and his collaborators have demonstrated that demineralization of the bones can be prevented, to a large extent, by calcium and phosphorus therapy, but that this usually causes increased irritation to the already damaged kidneys. They have justifiably decided that surgical treatment is the only effective one.

Doctor Washburn is to be congratulated upon his presentation of a case which demonstrates so many interesting and instructive points as his first one.

ACUTE ANTERIOR POLIOMYELITIS

THE POSSIBILITY OF THE SPREAD AS A RESULT OF DIRECT PERSONAL CONTACT: A STUDY OF 385 CONTACTS

By J. C. Geiger, M.D.
San Francisco

Discussion *by Karl F. Meyer, Ph. D., San Francisco; George M. Stevens, M. D., Los Angeles; E. B. Shaw, M. D., San Francisco.*

CONTAGIOUSNESS, through direct personal contact in epidemic and nonepidemic periods of acute anterior poliomyelitis, is regarded by many departments of public health as a settled fact. The quarantine laws, however, as to the length of isolation applicable to contacts of this disease, vary in states, counties, and cities. For instance, the regulations of the California State Department of Public Health require quarantine of contacts for two weeks, and the San Francisco Department of Public Health three weeks. The student of epidemiology is frankly at a loss in interpreting quarantine laws except from a legal standpoint, and perhaps all such laws should be remodeled in order to meet modern epidemiologic methods and knowledge. The degree of contagiousness or, better termed, the infectivity rate, as determined by secondary cases, which are attributed to contact, varies in epidemic and nonepidemic periods of acute anterior poliomyelitis. Moreover, the epidemiologic and clinical evidence appears definite and almost conclusive that the infectivity rate due to contact is far less in acute anterior poliomyelitis than from any other communicable disease. Perhaps the fact that the inciting agent is a filterable virus, possessing no unusual degree of viability, and whose entry into the body is generally the nasopharynx, may be the determining factor in the limited contagiousness due to direct personal contact. Epidemiologists today discuss freely familial susceptibility, scan the weather reports in time of seasonal periodicity of the disease, and give guarded statements as to the effect of blocking the nasopharyngeal passages by the use of chemical sprays. Again, the health official in times of elevated epidemic indices is confronted with the closing of schools or delaying of the opening, and the closing of swimming pools, theaters, churches, etc., to children of susceptible age.

MERIT OF PREVENTIVE MEASURES

The beneficial effects of any one of these allegedly important quarantine or preventive measures, even when they are put into operation in their entirety, appear to be decidedly controversial. Other disputed subjects are the use of convalescent serum in the treatment of the case and its value as a preventive measure in contacts, and the ultimate result to the patient in the use of the mechanical respirator. The San Francisco Department of Public Health recently has reiterated its stand that convalescent serum for treatment is logical, but only if administered early in the disease. The public fears the disease because of its power to cripple, quite often for life. If the residual crippling can be limited to a small percentage of the cases, at least one per cent, then the fear complex of the public should be dissipated. Therefore, early diagnosis and treatment are essential, and again the San Francisco Department of Public Health has insisted upon the establishment of diagnostic centers and the instituting of early orthopedic procedures.

DIAGNOSTIC CENTERS IMPORTANT

The most important and valuable measure to be established by the thoughtful health officer, therefore, is the diagnostic center, in order that an early diagnosis be made and early treatment instituted. The control of contacts by quarantine does not offer insurmountable legal difficulties, but the value of this measure must not be weighed too heavily. In 1917, the author reported an incident in Mill Valley, California,[1] in which a child of four and one-half years appeared at a party with sixty-six other children, ranging in age from two to fourteen, the majority under ten. The child had many symptoms of acute anterior poliomyelitis at the party; was fondled more than usual because of the illness; danced with many; was kissed by a number; used the same utensils and drinking glass in several instances; and the room in which the party was given measured only 20 by 30 feet. Moreover, Mill Valley had been free of the disease for several years; so, undoubtedly, this exposure constituted the first for many children present. No case of the disease developed in any of the sixty-six contacts. This author drew the following conclusion[1] "Therefore, taking everything into consideration relative to the sixty-six close contacts of the above case, particularly their supposed susceptible ages with the subsequent negative clinical results, and especially since, for the majority, it undoubtedly constituted a first exposure to the disease, there seems to be sufficient reason to doubt the accepted present-day theory of the spread of acute anterior poliomyelitis by direct personal contact."

SAN FRANCISCO EXPERIENCES

In 1934, contrary to outbreaks of previous years, the incidence of acute anterior poliomyelitis rapidly increased in San Francisco in the latter half of May, 1934, reaching its peak in the latter part of June. In previous outbreaks, the duration with the distribution of cases in 1916 was from July through January; in 1921, June through November; in 1925, April through December; in 1927, April through December; in 1930, June through February; in 1934, May to July. The last outbreak, in 1934, was reported in detail by the author et al.[2] One phase of the outbreak was not sufficiently studied, and consequently was not commented upon in this paper, namely, the study of contacts of cases.

One hundred and eighty-one close personal contacts of sixty-eight proved cases were carefully studied. The one hundred and eighty-one contacts were followed for at least six weeks by epidemiologists and the public health nurse. Only two of the contacts developed the disease. Ten of the remaining contacts showed at various periods of the time elevations of temperature, sore throat, muscular

pains, and malaise; but careful clinical observation and laboratory examination eliminated all as a clinical case of acute anterior poliomyelitis.

In the entire outbreak of 1934 there were 122 cases, with 307 direct personal contacts (an average of less than three per case), of which six (or 2 per cent) developed the disease. In 1937, in eleven cases reported over a period of several months, there were seventy-eight contacts, an average of seven per case. These contacts were followed closely for three weeks by epidemiologists and the public health nurse, and no cases developed, nor were there any symptoms to indicate a suspicion of the disease. The conclusion of the author, published in 1917,[1] therefore, could be applied in the outbreaks of 1934, an epidemic period, and to the contacts of the cases that were reported in 1937, a nonepidemic period. The epidemiologic conclusion, that individual susceptibility among age groups, where the susceptibility to acute anterior poliomyelitis is considered greatest, is practically negligible as a result of contact, appears valid in the light of experience in San Francisco in 1934 and 1937.

IN CONCLUSION

The epidemiologist must seek a more definite answer as to the modes of spread of this disease or accept the evidence that the population immunity is not an inconsiderable factor, since acute anterior poliomyelitis affects very few persons in a community in comparison to other communicable diseases. Furthermore, it is unfortunate that the Department of Health possesses meager or no information as to the source or route of infection in the cases reported.

Finally, if the diagnosis is made and the treatment administered early, especially orthopedic, the reduction of the residual and crippling paralysis will be such that the disease will become relatively unimpressive.

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DISCUSSION

Karl F. Meyer, Ph.D. (Hooper Foundation for Medical Research, University of California, San Francisco).—The experiences reported by Dr. J. C. Geiger coincide with those recorded in the international literature. In fact, the extreme rarity of sister infections, even in the vicinity of definite cases in a family, is so striking that the epidemiologist reluctantly accepts the concept of contagion for the disease poliomyelitis. Nobody will deny that the direct transfer of the virus from person to person is debatable, and for various reasons: (1) The infectiousness of the nasopharyngeal secretions of monkeys is fully proved, but well monkeys caged with poliomyelitic animals, or laboratory workers exposed to these apes, do not contract the disease. (2) In contrast to the droplet-borne infections—diphtheria and scarlet fever—the incidence of carriers is very low. An extensive spread of the specific disease agent in poliomyelitis has not as yet been proved. Lack of connection between cases of this disease is a constant epidemiologic feature; it is very difficult—usually impossible—to establish well-defined chain transmissions. This state of affairs is usually explained by the statement that the contacts are nonsusceptible. Would it not be better to separate clearly between susceptibility or disposition to infection, and susceptibility to disease? Seasonal incidence, lack of tendency to spread in congested centers, schools, etc., and the behavior of poliomyelitis in the tropics and in rural areas, are phenomena which do not harmonize with the concept of contact transfer, at least at the time the disease is clinically most prevalent. It is reasonable to suspect that the infective agent, perhaps a high molecular protein, enters the body many months before the clinical signs, induced by the intracellular parasitism, become evident. In the light of newer knowledge on viruses, the prevailing concepts of epidemiology may require radical revisions. The multiple cases reported by Bossert (Jahrb. d. Kinderheil K., 134:82, 1931) represent examples of exceptionally high genetic disposition to disease within two families, but this should not serve as proof that infantile paralysis spreads within the family.

Doctor Geiger feels keenly his inability to trace the sources or pathways of poliomyelitic infection. Everybody shares in this disappointment. An effective system of prevention cannot be instituted until the modes of transmission are established. The administrative measures in vogue are empirical and, consequently, ineffective.

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George M. Stevens, M.D. (Los Angeles City Health Department, Los Angeles).—One of the present-day mysteries of poliomyelitis is its evolution from a sporadic disease to one of epidemic proportions. It is conceivable that the causative virus may be of a specific neurotropic strain.

The low infectivity rate, due to direct exposure, can undoubtedly be explained by the large number of carriers who have developed an immunity due to repeated subclinic infections, and individual maturation. We must, however, be aware that on account of the prevalence of widespread epidemics, the infectivity rate and the age incidence are on the increase.

In the Los Angeles epidemic of 1934 there were 1,434 cases. The outstanding fact during the outbreak was the unprecedented incidence of the disease among the personnel of the Los Angeles General Hospital. This institution accounted for 234 cases. I am of the opinion that this was due to the repeated daily opportunities for direct and often prolonged contact. I do not believe that one single exposure was responsible for a clinical case, but due rather to several or many exposures of subclinical dosages. This, together, with other factors, such as fatigue, loss of sleep, overwork, and the constitutional make-up of the exposed individuals, were the determining factors in the development of the clinical manifestations of the disease, or subclinical immunity.

The shifting hospital personnel during the outbreak was approximated at 4,522, and the gross attack rate was 4.8 per cent. The groups most severely attacked were the physicians and the nurses, with a gross rate each of 5.4 and 10.7 per cent, respectively. More striking was the fact that those nurses most closely associated with clinical cases had an attack rate of 11.4 per cent, while those physicians in such attendance had an attack rate of 6.2 per cent.

The disease first attacked and reached its greatest intensity among the newcomers of the hospital personnel, who gave no history of any previous exposure. Student nurses had the highest attack rate of 16.2 per cent, while the graduate nurses affected were 8.2 per cent. A much smaller attack rate was manifested among the attendants, with a rate of 1.9 per cent, and among the orderlies of only 1.6 per cent.

The attack rate among the hospital personnel, whose occupation never brought them into any intimate contact, was only 0.8 per cent. Residence on the hospital grounds also played a rôle. The attack rate among those residing on the grounds was 14.2 per cent, while those living outside the grounds was 2.3 per cent. All of the foregoing hospital statistics are quoted from the excellent study and report of Dr. A. G. Gilliam, past assistant surgeon of the United States Public Health Service. We trust that this excellent survey will soon be published for distribution.

Our analysis revealed that, of the total of 1,434 cases during the outbreak, there was a definite history of known exposure in 301 instances, or approximately 21 per cent. Secondary cases occurred in eighty-two households and were distributed as follows: two cases in each of seventy families; three cases in each of nine families; four cases

in each of two families; and in one household there were six cases. Multiple or secondary cases occurred in 6.21 per cent of the cases in the series. This rate compares closely with the attack rate of 6.1 per cent that occurred among the hospital personnel, who were more or less in close contact with the clinical cases.

Consequently, it is my opinion that direct contact, especially if associated with prolonged exposure, lack of opportunity to develop subclinical immunity by repeated small contact doses, fatigue, loss of sleep, and the constitutional make-up of the individual, all play a very important rôle as to whether an individual actually develops poliomyelitis or becomes subclinically immune. Surely, the spread can be controlled to some degree by the isolation of the patient and the restriction of the contacts. By so doing, we will help to prevent overwhelming exposure doses to many susceptible individuals, giving them a chance to build up protection by subclinical means.

Until confronted with more knowledge in regard to the spread of the disease, we are willing to accept the now prevailing opinion that it is spread by droplet infection from those ill with the disease, and often by carriers, who have themselves developed subclinical immunity.

I am in accord with Doctor Geiger's emphasis on the establishment of diagnostic centers for the early diagnosis and hospitalization of suspected cases. The use of nasal sprays can only be of limited usefulness. It has its drawbacks and dangers at the present time and, under these circumstances, cannot be of practical aid in the field of public health. I believe that the hope of the future for the control of poliomyelitis still lies in the development of a safe and efficient vaccine.

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E. B. Shaw, M.D. (384 Post Street, San Francisco).—It must be admitted by any student of epidemiology that quarantine is frequently a process of closing the door after the horse is out, and is only justified by the argument that there may be other horses. In poliomyelitis, as in most infections, clinical diagnosis is established only after the patient has, in all probability, passed through his period of greatest communicability and, doubtless, thereafter continues to be a potential disseminator of virus but, due to the fact that he is then an ill child, the opportunities for dissemination are considerably cut down and he is not nearly so dangerous to the community as he was for a short time before the development of active symptoms. Doctor Geiger's observations indicate that, while the patient with poliomyelitis is not demonstrably a frequent source of other cases, the infection chain in this disease is, however, most obscure; and cases intermediate between a pure carrier state and outspoken paralytic forms of the disease are a likely agency for distributing the infection to the population. These disseminators of the infection are not readily detectable by ordinary methods, they are not clinically recognizable, and the virus cannot be demonstrated in their secretions with the ease with which diphtheria bacilli may be detected.

It is not altogether rare, however, as even Doctor Geiger's series demonstrates, to find the disease developing after contact with a known clinical case. Without completely reviewing the cases of poliomyelitis which I have seen, I can quickly recall several instances: (1) three children in one family developed the disease at intervals of four or five days; (2) a four-year-old child was exposed to a patient in another town, and developed the disease five days later; (3) at least three of the mothers who cared for small children during the early stage of the disease developed poliomyelitis within a week following their first exposure; (4) a child intimately exposed to her sister, who died of the bulbar form, developed poliomyelitis twelve days later with an almost identical clinical picture. I believe that these instances could be multiplied by a careful study of the intimate history of many cases. It has always been my belief that, although numerous individuals may be exposed to this disease without contracting it, intimate exposure is not necessary for the infection of the patient whose susceptibility is modified by constitutional and environmental factors which predispose him to infection. I suspect that the disease passes from one patient to another by means of an infection chain which includes the clinical case, the subclinical case, and perhaps even includes the healthy carrier.

Dissemination of the virus throughout the community is only a single factor in the production of epidemics; there are many reasons to suspect that numerous environmental factors must be propitious before an epidemic can develop. Until these environmental factors are more precisely known there is little which can be done from a public health standpoint, except to make an effort to reduce dissemination of the infectious agent, and this can only be partially secured through the isolation of cases and contacts. During seasons of increased epidemicity, when presumably environmental factors favor the disease, it is especially desirable to make every effort to avoid scattering infection, even though demonstrable case-to-case connections are not evident.

Doctor Geiger's observations emphasize simply the obscurity of our state of knowledge regarding the precise epidemiology of poliomyelitis. It might be relatively safe to enforce *no* isolation for the affected individual, but even a small degree of risk is incompatible with the nature of the disease, and the fear which it engenders in any community. St. Paul was responsible for the advice, "To abstain from the appearance of evil." This may not be valid epidemiology, but it is sound public health, from which I do not believe Doctor Geiger would propose any departure. There is no doubt that the study of epidemics from the standpoint of public health deserves the earnest coöperation of the clinician, who alone can supply a wealth of intimate detail regarding the individual patients helping to comprise the epidemic.

FUNCTIONAL INDIGESTION *

By Alfred E. Koehler, M.D.
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Discussion *by William C. Boeck, M. D., Los Angeles; T. L. Althausen, M. D., San Francisco; Hugh Freidel, M. D., Santa Barbara.*

FUNCTIONAL indigestion may be defined as a disturbance of the digestive and assimilative functions in which no organic pathology can be demonstrated. Although many factors influence alimentation, in general well-masticated food undergoes proper digestion when (1) an adequate amount of the various digestive secretions is available; (2) when gastro-intestinal motility is neither excessively slow nor fast; and (3) when absorption of the products of digestion or of the simpler foodstuffs by the blood stream or by the lymphatics is adequate. By adequate in this respect, we mean that unabsorbed foodstuffs do not reach the colon or if so, only in relatively small amounts.

It is, of course, altogether probable that digestive disturbances due to organic causes, such as peptic ulcer or cholelithiasis, are related reflexly to these same factors. Removal of the organic lesion usually clears up the disturbance, and little thought is ordinarily given to the actual physiological mechanism involved.

In this study we have confined ourselves purely to those cases in which organic pathology has been ruled out as far as possible. The error is frequently made of assuming a functional diagnosis without eliminating such factors as ulcers, gall-bladder and liver disease, constriction, adhesions, diverticulae or congenital malformations. Failure of proper roentgenographical studies frequently is due to economic considerations, but experience teaches us that such economy is usually expensive in the end. We

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TABLE 1.—*Limits of Variation Into Which 90 Per Cent of Normal Cases Fell*

Rate of flow	0.8 to 1.6 cubic centimeters per minute
Icteric index	25 to 60 times dilution
Amylase	200 to 500 milligrams sugar
Lipase	18 to 25 cubic centimeters 0.1 N NaOH
Protease	4.0 to 6.0 milligrams amino nitrogen

strongly urge that indigestion of any prolonged duration be not assumed as functional, but that every effort be made to rule out organic disease.

However, after such pathology is ruled out as far as possible, a considerable group remains that must be classified as functional disorders.

PLAN OF STUDY

Our approach to this problem, which too commonly is handled in a vague and purely symptomatic fashion, has been through channels of objective and quantitative diagnostic studies concerning digestive secretions, motility, and absorption. The latter two factors are, of course, intimately related, and dissociation, at least for the time being, has been difficult.

DIGESTIVE SECRETIONS

By means of a duodenal tube and a modified technique we have studied the duodenal secretions under basal conditions in 38 normal, 280 abnormal, but without digestive disturbances (malnutrition, adiposity, diabetes, allergy, etc.), and 710 cases of indigestion. Such studies have been reported previously by various workers, with the general conclusion that little value can be attributed to such findings. It is our belief that such failures have been due to: inadequate standardization of the drainage technique, poor methods of analysis, inconclusive data on the normal limits of variation, and failure to obtain more than one drainage in questionable cases.

The drainage material was analyzed immediately after it was obtained. The digestions were done at 37.5 degrees centigrade, in a special type of incubator in which a shaking platform kept the mixtures in constant gentle agitation. The digestions were all carried out in a phosphate buffered solution at pH 7.0 (the probable average pH of the contents of the small intestinal tract) and expressed in the following manner:

Rate of Secretion. Expressed as cc. collected per minute.

Icteric index (bile pigments). Dilution of drainage necessary to match colorimetrically 0.01 N potassium dichromate solution.

Amylase. Mg. sugar as maltose liberated from 1 cc. of 1 per cent starch solution by 1.0 cc. secretion in 10 minutes at 37.5° C.

Lipase. Cc. of 0.1 N NaOH required to neutralize the fatty acids formed from 2 cc. olive oil by 10 cc. secretion shaken (emulsified) in an incubator for three hours at 37.5° C.

Protease. Mg. of amino-acid + NH_3 nitrogen obtained from 250 mg. casein by 10 cc. secretion shaken in incubator for three hours at 37.5° C.

Table 1 shows the limits of variation of 90 per cent of the normal cases, while Table 2 shows the

TABLE 2.—*Incidence of Abnormal Findings in 305 Cases of Indigestion*

	Per Cent Below Lower Range of Normal Variations
Rate of flow	29
Icteric index	47
Amylase	26
Lipase	13
Protease	17

incidence of abnormal findings in the indigestion cases. We believe that the figures for decreased rate of flow, bile pigments and amylase in indigestion are significantly outside the values for normal variation, while those for lipase and protease are only questionably so. On the other hand, it is also well shown that a considerable percentage of the indigestion group have drainage values well within the normal variation limits, and that the cause for indigestion in these cases must be sought for in abnormalities other than digestive secretion deficiencies in the upper duodenum. Insufficiency of digestive secretions in the jejunum and ileum (succus entericus; erepsin, sucrase, lactase, etc.), has never been adequately studied.

STARCH INTOLERANCE

The high frequency of starch intolerance, as cited by patients in obtaining their histories, and the high percentage of amylase deficiency in the duodenal drainages made it desirable to devise a further quantitative test for this difficulty. This we accomplish by giving 1.5 gram of cornstarch suspended in water per kilo body weight in the same manner as for the glucose tolerance test and determining the glucose absorbed in the blood during hour intervals. In the normal person there is an excessive amount of amylase available, so that the rate of absorption of the sugar formed becomes the limiting factor and, consequently, the blood sugar curve after starch is similar to that after glucose. In many cases of indigestion, however, the blood glucose curve after starch is greatly flattened, frequently no elevation at all being noted. Commonly, such cases have nausea, flatus, distention, occasionally headaches and general malaise six to twelve hours after the starch ingestion, due probably to the undigested starch reaching the colon and undergoing rapid fermentation. Chart 1 shows the comparison of starch and glucose tolerance curves in a normal and a case of starch indigestion.

SIMPLE SUGAR INTOLERANCE

A considerable number of cases give the history of not tolerating simple sweets. Frequently, such small amounts of sugars (10 to 15 grams) caused upsets when administered in a test-meal, even when disguised, that the question of allergic intolerance was raised, but this was felt to be improbable because large amounts of these same sugars (sucrose, lactose, xylose and glucose) given intravenously to these patients produced no disturbances. In the case of glucose intolerance the factor of digestion

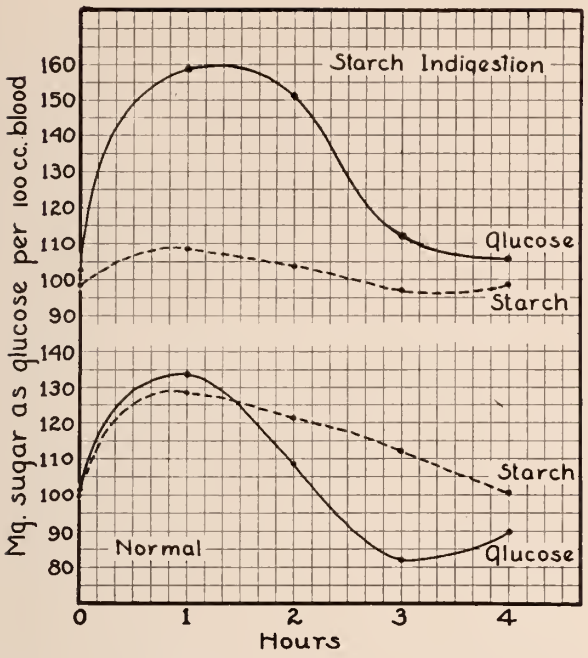


Chart 1.—Demonstration of failure of blood sugar rise after starch ingestion in a case of indigestion as compared with the normal rise in blood sugar after the same amount of glucose.

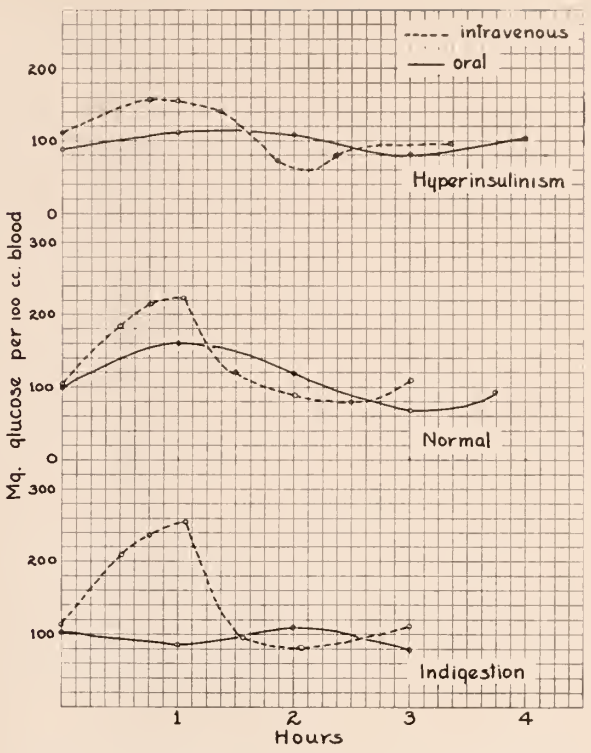


Chart 2.—Demonstration that the flat blood sugar curve after glucose ingestion may be due to failure of absorption. Such flat curves may be differentiated from those of hyperinsulinism by the intravenous administration of glucose.

can be eliminated, and consequently we turned our attention to its rate of absorption. Glucose tolerance tests by mouth in this type of a case frequently show only slight or no rise of the blood sugar afterward. Such a flat curve, of course, could be due either to faulty absorption from the intestinal lumen or to excessively rapid utilization of the sugar after absorption such as is obtained in cases of hyperinsulinism. That the latter was not always the case and that, consequently, the flat curve was due to poor absorption, was proved by demonstrating a normal or even poor utilization tolerance by continuous intravenous injection of glucose at a constant rate.

The distress that these people, with impaired glucose absorption, have after sugar ingestion is similar to that mentioned under starch indigestion.

Chart 2 gives examples of oral and intravenous glucose tolerance curves in normal, hyperinsulinism and sugar intolerance cases.

As to the type of disorder responsible for decreased sugar absorption, little is known. The possibility exists that decreased absorption is due to increased intestinal rate, and that there is a comparable decrease in the absorption of other substances such as amino-acids as well.

TREATMENT

It should be emphasized, of course, that many other factors exist that cause or are related to indigestion than those included in our discussion. Among these may be mentioned allergy and less specific food intolerance, such as that produced by cooked cabbage, lettuce, radishes, etc. We purposely avoid discussion of the vague term *nervous indigestion*; not that nervous disturbances are not important, in fact they are of fundamental importance, as has frequently been shown by various workers, but we prefer to think in terms of the type of alimentary disturbance caused by aberrant nervous activity.

Our experience leads us to believe that an excessively rapid, small intestinal rate is the most common cause of functional indigestion, and that distress is caused by an excessive amount of bacterial food reaching the colon. Treatment consists of the well-known methods, avoidance of foods mechanically or chemically irritating, and nervous stabilization. This latter aspect is a problem of such magnitude that no attempt can be made to review it here. One point in regard to nervous irritability we do wish to emphasize, namely, malnutrition, frequently a result of indigestion or imposed dietary restrictions. We emphasize, in this respect, a well-balanced dietary regimen, with particular attention paid to the mineral and vitamin requirement, frequently augmenting the diet with the pure forms, especially calcium and vitamins B^1 and C.

TREATMENT OF PATIENTS WITH DIGESTIVE SECRETION DEFICIENCY

Motility is, of course, closely related to secretory deficiency, inasmuch as a fast rate greatly decreases the time of action of the enzymes on the substrate.

In general, secretory deficiency can be treated in one of three ways or combinations of these procedures:

1. If the deficiency prevents proper utilization of one of the food groups, this group may be materially reduced in the diet. For example, cases frequently are low in amylase but have adequate lipase and protease, and consequently are given a diet

low in starch and higher in protein and fat. Similarly the avoidance of more than the minimum of sugars greatly benefits cases that have poor absorptive ability.

2. The deficiencies may be substituted for by enzyme concentrates such as diastase, malt, and pancreatic preparations. The difficulty seems to be that the activity of these preparations is so low and irregular that efficient concentrations in the intestinal tract are hard to obtain. We are convinced that unprotected pancreatic amylase is completely destroyed by the gastric acidity. We have not been able to alter low starch tolerance curves with the most active amylolytic preparations available, even when enteric coated. On the other hand, many patients report general digestive improvement with these preparations, but such criteria is frequently difficult to evaluate.

3. The low secretory activity of the digestive glands may be stimulated, at least in certain cases. Food itself is probably the best stimulus, and low secretory activity can frequently be related to long periods of partial starvation, frequently imposed to avoid digestive distress. Encouragement to eat adequately of the proper foodstuffs frequently is followed by improvement of the secretory functions with general improvement.

The secretory impairment is frequently related to low general metabolic activity, as in cases of hypothyroidism, and probably in anterior pituitary lobe deficiency of the lean type. Thyroid treatment is frequently effective.

Furthermore, evidence is accumulating that certain vitamin deficiencies, particularly B_1, result in impaired motor and secretory activity of the intestinal tract, and we believe that our data, although still in the experimental stage, indicates the usefulness of vitamin B^1 therapy in these types of cases.

Santa Barbara Cottage Hospital.

DISCUSSION

WILLIAM C. BOECK, M.D. (1919 Wilshire Boulevard, Los Angeles).—One must unhesitatingly commend Doctor Koehler for the industry which his research represents in the field of functional indigestion. It was motivated, no doubt, by a desire to learn whether or not there is some detectable physiological disturbance that may account for the digestive symptoms in that group of patients presenting no evidence of organic pathology.

The investigation seeks to show that in many of these patients the digestive disturbances may be based upon their inability to metabolize starch in a normal manner. The evidence that this exists is based upon the low or flat starch-tolerance curve obtained in many of such patients. This curve is interpreted to mean that much of the ingested starch is not digested and absorbed, but passes on into the colon, where it is acted upon by the bacteria; the fermentation produces gas, which results in the flatulence, distention, abdominal pain or distress, nervousness, etc., so commonly complained of by these persons.

I believe, however, that this finding, while it may prove to be a contributing factor, cannot be said to be established by this work, because this research only deals with pancreatic digestion, and the blood-sugar curve represents absorption over only four hours. This undoubtedly represents the maximum absorption from the digested starch, and that which probably occurs for the most part in the duodenum, jejunum, and upper ileum; but digestion and absorption may still continue on down in the ileum, and perhaps the colon, too. We would like to have evidence that undigested starch actually reaches the colon in large amounts. The intubation methods of Abbott, Karr and Miller of Philadelphia might be used to clarify this point.

As the author states, such important factors of malnutrition and undernutrition, and the nervous irritability so common in these patients must be considered in treating them. Too often these patients have practiced progressive food exclusion from their diet, with the result that a deficiency state may exist. The indigestion symptoms gradually disappear when the treatment is handled intelligently to include an adequate balanced diet and a proper evaluation of all other factors that may have had a part to play in the production of the digestive symptoms. This investigation deserves much credit as another step in the direction of explaining the probable origin of some of these symptoms.

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T. L. ALTHAUSEN, M.D. (University of California Hospital, San Francisco).—The subject of deficient action of digestive enzymes in the body is decidedly in need of quantitative study, and Doctor Koehler's work is a valuable step in this direction. It is reasonable, as the author states, that diminution of amylase in the duodenal fluid does not necessarily mean failure of starch hydrolysis, because normally an excess of amylase is present. Doctor Koehler very properly advocates further studies in the nature of a starch meal, and if necessary a test of glucose tolerance by the intravenous method before the existence of improper splitting of starches is seriously considered. Even then it remains not entirely proved, because in a cornstarch test-meal the digestive action of the amylolytic ferment of saliva appears to be largely excluded.

The question of whether increased peristalsis has an adverse influence on absorption was brought up. We found that experimentally induced intestinal hyperperistalsis in animals reduced the hourly absorption of glucose from 1.7 gram to 1.4 gram per unit of body weight. We also found that starvation up to four days, hepatic injury due to phosphorus poisoning, fever, and dinitrophenol intoxication, all produced some diminution in absorption of glucose. However, the thyroid status of animals had the greatest influence on absorption. Thyroidectomy reduced the absorption of glucose in our animals to 0.9 gram, while administration of thyroxin increased it to 2.8 grams.

I agree with Doctor Koehler that, clinically, hyperperistalsis of the small intestine may cause intolerance to starches; but I also think that other factors which bring together unabsorbed carbohydrates and intestinal bacteria, such as excessive intake of starches or extension of the colonic flora into the small intestine, can produce the same effect.

Therapeutic administration of digestive enzymes is at present in such disrepute that the Council on Pharmacy and Chemistry of the American Medical Association does not accept any enzyme for oral administration. This state of affairs is due to the fact that digestive enzymes are almost universally given regardless of whether objective evidence of a deficiency exists, and that the amounts given are usually too small to be effective except as a form of psychotherapy. The clinical importance of the digestive enzymes will come into its own when we shall be able to prescribe them only in proved cases of deficiency and in amounts that are physiologically active. Doctor Koehler's work brings us a step nearer to this goal.

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HUGH FREIDEL, M.D. (1515 State Street, Santa Barbara).—Doctor Koehler should be congratulated for presenting these studies to us. More and more worth while studies of the small intestine functions are being reported daily, chiefly biochemical in nature. They all add something valuable to our knowledge of the abnormalities of the intestinal mechanism, and are of increasing aid to us in the caring for the same. Further contributions will be continued by just such studies as Doctor Koehler has made, and we all look forward to the gradual clearing of those hazy and uncertain ideas that are so prevalent concerning this most important digestive organ, the small intestine. It is to be hoped that further studies of the intestinal motility will offer to our knowledge new and worth while contributions, for I feel the disturbances in the motility, and the factors influencing them, are of the utmost importance.

I have felt the evaluation of quantitative estimations of the secretory functions of the small bowel to be of some benefit in diagnosis, but very little in therapy. And this

was due to the definite variable influences on the secretion by psychic and emotional stimuli so prevalent in the group of emotionally unstable individuals encountered. Doctor Koehler has apparently disposed of these factors to his satisfaction in his presentation of this study. All have seen cases of starch intolerance with frothy, fermentative stools, and with definite clinical evidence of marked indigestion, who, when away from their family and business worries, have metabolized starch in an adequate and satisfactory manner. Functional deficiencies, as determined by such laboratory findings, should be more constant.

I agree with Doctor Koehler that substitution therapy, using the various enzyme and digestive concentrates, is very disappointing. In order to get any benefit, even in the most evident case, much larger doses than usually used are necessary, and then only with preparations of a proved potency. Good results have been reported by using a properly prepared potent preparation of pancreatic juice in proved cases of pancreatic insufficiency. Ivy reports good results with large doses of pancreatin of proved potency in similar cases. Therefore, it seems to me that if the deficiency is real and not transitory, preparations of these concentrates, properly prepared and of known potency, would be of a greater benefit to these functional indigestions.

When we have further studies of the small intestine physiology, and especially its motility, made available most probably by new and improved roentgen studies, with a more skillful guiding and helping of these individuals to adjust themselves to their handicaps and to live within their capabilities, then and only then will our therapeutic results with these various functional indigestions and disturbances in motility of the small bowel be satisfactory.

THE ENDOCRINES AND BEHAVIOR IN PUBERTY*

By Clara H. Spalding, M.D.
Richmond

Discussion *by Olga Bridgman, M. D., San Francisco; E. Kost Shelton, M. D., Los Angeles.*

THE child from eleven to sixteen is here discussed. The reasons for believing this group worthy of special consideration are threefold:

First: The universality of this critical time in every child's life.

Not every child will have broken bones or acute infection; but each child will, inevitably, have a period of puberty with its problems.

Second: Because of the importance of this period to the child himself, physically and emotionally.

Third: Because of the importance of the adjustment of the child toward society; the social economic value.

THE PHYSICAL CONSIDERATION

Pubescence interests us primarily because of its physiological changes, and the underlying anatomical changes, which means consideration of the endocrines.

The sum total of the child's previous life gradually brings to bud and blossom the gonadal system; the sex hormones of the pituitary gland, plus gonadal activity.

RÔLE OF THE PITUITARY

Regarding the pituitary as the keystone of the arch, we may pass lightly over the products of the posterior lobe, simply naming them for completeness:

1. That which affects the liver and so aids in fat metabolism.
2. That which aids the eye in mydriasis.
3. Three which affect the circulatory system:
 (*a*) Raises blood pressure.
 (*b*) Aids coagulability.
 (*c*) Controls capillary tone.
4. Two which bear upon the renal system:
 (*a*) Diuresis.
 (*b*) Antidiuresis.
5. Two which affect the uterus:
 (*a*) Alphahypophamin, the pressor.
 (*b*) Betahypophamin, the oxytocic principle.
6. Two which bear upon the digestive system:
 (*a*) One to the stomach, an inhibitor or gastric secretion.
 (*b*) One affecting the peristaltic action of the intestine.

One product of the pars intermedia:

1. Intermedia.

Then those of the anterior lobe, of whose eight products we mention seven briefly:

1. Parathyreotropic, parathormone.
2. Thyreotropic, thyrodin.
3. Suprarenalatropc, adrenalin or cortin.
4. One with galactagogue action.
5. Pancriaticotropic, insulin activator.
6. One affecting general growth.
7. One affecting skeletal growth, specifically.
8. The gonadotropic group, which we shall consider more closely.

GONADOTROPIC GROUP

Of the gonadotropic group, we have:

Prolan A, of which we have a male and a female entity:

1. That which affects the testicle, and whose specific function is the determination of spermatogenesis.
2. That which affects the follicle of the ovary—folliculin.

Prolan B, which, likewise, consists of a male and a female entity, as the case may be:

1. That which affects the testicle androtin.
2. That which affects the corpus luteum, progestin.

When the gonadotropic hormones mature and function normally, we have the group of secondary sex characteristics develop normally. If this physiological function be normal, we have the resultant normal emotional response on the part of the child, which predetermines that child's attitude toward life and society.

GROUPING OF CHILDREN

Children may, grossly, be divided into three groups:

First: The narrow top band of the precocious.

These children require great tact and understanding. Their ability to lead can be guided correctly, or they may easily develop their smart-aleck tendencies to be leaders of gangs.

Second: The bottom, much wider band of subnormals. The gradations range from:

1. The mildly retarded.

2. The feeble-minded—high-grade and low-grade morons. These are a definite menace to society because they are not adjusted, and are not capable of adjustment to the social economic system of today, with its complex problems.

The only hope for these two groups is early recognition, correct diagnosis, and adequate treatment of their endocrine dyscrasias.

* Read before the Pediatrics Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–5, 1937.

3. The twilight zone, the very low-grade mentals: the imbeciles and the idiots. Their only solution is institutionalization.

But many cretins and Mongolian idiots could have been spared this fate had their endocrine needs been recognized early. That would have been both humane and economical.

Third: That broad, middle band of good normals. Fortunately, these constitute the vast majority. From this group will always come our substantial citizens of the future.

They need no special medical attention, only understanding and sensible training.

EMOTIONAL REACTION OF THE PUBESCENT CHILD

With the pubescent child, bear in mind that he is undergoing an emotional crisis. He is confused, feels frustrated. He cannot understand himself, therefore he thinks nobody understands him. He is becoming an independent social unit with definite opinions. He is becoming an adult, so what he needs is someone to regard his problems as dignified and important, which is every adult's due.

SEX INSTRUCTION

Sex instruction should be provided. This may well be given by the parents, if they are intelligent, if they have the child's confidence, and if they are themselves instructed. It may be given by the family physician, if he is sufficiently close to the child to impress the child that he is really vitally interested in his welfare. Or it may be imparted at school, which can much better give sex-hygiene instruction than sex instruction.

Sex instruction, to be worth while, must be given not too early in life; it must not be too legendary nor romantic; it must be clear, and it must be scientifically sound.

IN CONCLUSION

The child who becomes maladjusted, in the majority of cases, follows this rationale:

First: Endocrinopathy.

Second: Development of undesirable traits and habits.

Third: Early juvenile delinquency.

Fourth: Criminality.

Endocrine disorders are amenable to treatment and are correctible, if diagnosed correctly, and treated early and adequately.

331 Eighth Street.

DISCUSSION

Olga Bridgman, M.D. (University of California Hospital, San Francisco).—For many years it has been the high desire of those of us concerned with various human problems to find some one basic cause which could be attacked in order, at one stroke, to eliminate such problems as feeblemindedness, crime, and mental disorder. Lombroso felt that he had hit upon such a fundamental cause in developing his theories of degeneracy. From time to time other panaceas have been advanced. Now endocrinology, still to a large extent in its very experimental stage, is perhaps a refuge for the very optimistic. What may be accomplished in the future by endocrine therapy can scarcely be predicted with any scientific accuracy, but some of us who have seen the complete failure of such treatment in scores of cases of mongolian imbecility, and have been disappointed in the use of thyroid therapy even in apparently clear cases of childhood myxedema, tend perhaps to be too pessimistic. It may be true that all maladjustment is primarily endocrine, but there are many other contributing causes of a social and psychological sort on which we must work, pending the discovery of any proved first cause.

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E. Kost Shelton, M.D. (921 Westwood Boulevard, Los Angeles).—Volumes could be written, in fact some have been written and very badly, on glands and personality. Suffice it to say, that those which I have read, including the article by Doctor Spalding, put too much emphasis on the glands of internal secretion as the direct cause of the personality pattern of the child.

Everyone will concede, in this day and age, that the pituitary is the regulator of numerous physiologic functions; but to predict just how many abnormal behavioristic leanings can be attributed to dysfunction of this organ *per se*, is a hazardous guess. It has always appeared strange to me that those suffering from demonstrable pituitary disorder, or whose pituitary dysfunction has been verified at autopsy, appeared to show the least change in personality pattern. To me the abnormal behaviorisms incident to tallness in girls, shortness in boys, genital hypoplasia, obesity, extreme thinness, etc., while real, are somatopsychic inferiorities, for which children compensate in various ways, mostly badly, rather than the result of hormonal imbalance *per se*. Some children compensate atrociously for these unsightly mechanisms, but I have never found a pill or a shot which would cure them without also some sensible psychologic readjustment. This treatment is frequently applied subconsciously by the physician during his course of physical rehabilitation.

Almost every day, when handling a large volume of work of this nature, one sees children with severe constitutional inferiorities, minor birth injuries, developmental cerebral defects, children with doting, foolish mothers or improvident fathers, who are being treated for their mental quirks with various endocrine products, especially new pituitary preparations that are sometimes in a very inadequate form and dosage.

Doctor Spalding's paper shows sincerity of purpose, and no doubt she knows all of these things, selects her patients carefully, and treats them well; but many busy practitioners whom this article will reach know little of the subject and thirst for knowledge. I am afraid that her article, interpreted dogmatically, would encourage rather than curtail the present indiscriminatory practice as regards the endocrine treatment of abnormal behaviorisms of the child.

ABDOMINAL ABSCESSES: THEIR TREATMENT

By Thomas O. Burger, M.D.
and
Harold C. Torbert, M.D.
San Diego

Discussion *by Robert A. Scarborough, M.D., San Francisco; Bon O. Adams, M.D., Riverside; Joseph J. O'Hara, M.D., San Diego.*

ANY method which promises to reduce the mortality from infections of the peritoneum deserves the attention of every surgeon. The purpose of this paper is to call attention to certain precautions in the treatment of abscesses in and adjacent to the abdominal cavity. The procedures to be described are not new,[1] but are so generally neglected, and in our hands have proved so potent in saving life, that it is felt worth while again to bring them to the attention of all surgeons.

TWO TYPES OF LOCALIZED ABSCESSES

Two general types of localized abscesses may be recognized: (1) Those following an inflammation

of the peritoneum, either local or general, and (2) those formed extraperitoneally. Examples of the first class are the ordinary appendiceal abscess, pericholecystic and pelvic abscesses, and those following slowly perforating peptic ulcers. Pancreatic, retrocecal and broad ligament abscesses are common examples of the second type.

PATHOLOGIC BACKGROUND

A knowledge of the pathologic processes involved is the first step in evolving proper methods of treating these lesions. The review given here is taken almost verbatim from Hertzler's monograph on surgical pathology of the peritoneum.[2] When infection begins in an organ covered by the peritoneum, the latter immediately initiates a series of defensive measures. The serosa becomes hyperemic for a considerable distance beyond the site of infection, and a fibrinous exudate appears on the surface. This is ready to adhere to adjacent surfaces, and usually with the aid of the omentum, which becomes plastered down over the site of the lesion, the infected area is walled off. Following the formation of this confining wall, the hyperemia beyond the immediate region of the abscess lessens; the exudate on the peritoneal surface and about the vessels is absorbed, and the peritoneum, except that part actually concerned in the formation of the abscess, returns to normal. In other words, that part of the peritoneum not concerned in the walling-off process is no longer in a state of defensive reaction.

If, now, the abscess is opened through the peritoneum either by the surgeon or by spontaneous rupture, pus flows over unprotected peritoneum. It is evident that the rational method of dealing with these lesions is to drain them extraperitoneally. In many abscesses, notably those occurring retrocecally and in the cul-de-sac, this can be done at once with comparative ease. In the remaining cases where the abscess is so located that it is impossible to avoid opening the peritoneum to get at it, a simple two-stage procedure will secure the same effect.

LOCALIZED ABSCESSES OF ABDOMEN

A large proportion of the localized abscesses of the abdomen occur following rupture of acutely inflamed appendices. This complication is particularly frequent following retrocecal appendicitis. The usual procedure is for the surgeon to make either a McBurney or right-rectus incision and tear away the adhesions. He then either removes the appendix and drains the abscess, or perhaps contents himself merely with draining the abscess. It really makes little difference, because in either event 20 to 50 per cent of his patients will die. Of course, he drained the abscess—and the drain cleared out a little channel not more than one centimeter in diameter surrounding the drain.

RETROCECAL ABSCESS

When for any reason the surgeon suspects the presence of a retrocecal abscess, the proper procedure is to begin the incision just over the crest of the ilium. The incision may then either be carried forward, close to the ilium anteriorly, or extended posteriorly, as for work on the lower ureter, as point-tenderness during palpation of the abdomen shall have indicated. Care should be taken to stay retroperitoneally until the abscess is approached. If there is any doubt that it has been reached, a large caliber needle may be used to demonstrate the pus cavity, which may then be opened by blunt dissection. If the appendix can be easily palpated, it should be ligated and removed. Otherwise, it is advisable to limit the operation to drainage of the abscess.

Occasionally one will suspect an abscess of this type but, on exploration, it will be found to be wholly within the peritoneal cavity. In such cases, the incision should be extended anteriorly, the peritoneum opened, and with one finger retroperitoneally and one finger in the abdomen, the abscess may be definitely located and retroperitoneal drainage instituted without soiling the peritoneum.

UNSUSPECTED ABSCESS

If, however, the surgeon has not suspected the presence of an abscess in advance and has made the usual gridiron or right-rectus incision, a somewhat different technique may be used. Every attempt should be made to avoid rupturing the abscess. The surgeon should content himself with placing a vaselin gauze drain down to the wall of the pus cavity, at the point nearest the surface. In a few days a protective wall of adhesions will be formed about the drain, constituting a pus-tight tube leading to the surface. The drain may then be withdrawn and the abscess opened with a hemostat or the finger. In many cases this will not be necessary: the drain will have adhered to the wall of the abscess cavity, which will rupture spontaneously into the drainage tract.

This two-stage technique is applicable to practically all abdominal cavity abscesses, the location of which makes one-stage extraperitoneal drainage impossible. We have used the method successfully to treat abscesses following rupture of intestinal diverticula, and those due to slow rupture of peptic ulcers. It also affords a fairly satisfactory method of dealing with abscesses which are completely retroperitoneal but which, because of their location, are difficult to drain extraperitoneally, such as those following infection of the pancreas.

The two-stage technique is particularly valuable in treating abscesses remaining after partial recovery from general peritonitis. Here the precarious condition of the patient, already weakened by a long and serious illness, makes a second infection of the general peritoneal cavity a matter of the gravest import. Seventy-five per cent of such patients will surely die if drainage is attempted transperitoneally. This mortality can be reduced to between 10 and 25 per cent if the draining is performed in two stages.

COMMENT

A final word of caution is perhaps necessary. Locate your abscess and place your drains without too much curiosity as to the original source of the infection.

In a series of thirty-seven cases of retrocecal appendiceal abscess in which either immediate extraperitoneal drainage or the two-stage operation was employed, we had no deaths. In five of the cases the appendix was found, ligated, and removed. Two of the remaining patients had to be operated upon a second time, one for a persisting fecal fistula through the stump of the unremoved appendix, and the other for a second abscess. Not only was the mortality zero in this series, but in practically all cases the postoperative course was smooth and convalescence rapid.

SUMMARY AND CONCLUSIONS

1. The pathology of localized abscesses in the abdominal cavity is briefly reviewed.

2. Extraperitoneal drainage of such abscesses is easy to do in some, but requires a two-stage procedure in others.

3. A two-stage operation is described for use in locations where primary extraperitoneal drainage is difficult or impossible. In the first stage, gauze drains are placed down to the wall of the abscess, with closure around the drain. Two to four days are then allowed for formation of a protecting wall of adhesions about the drain before the latter is removed and the abscess opened at the second stage.

4. In a series of thirty-seven cases of retrocecal appendiceal abscess drained by either the primary extraperitoneal or the two-stage method, there was no mortality. The postoperative course in all but two of these patients was entirely uneventful.

5. It is concluded that the mortality from localized abdominal abscesses can be materially reduced by the use of either primary extraperitoneal drainage or the two-stage method of forming an extraperitoneal drainage channel.

2120 Fourth Avenue.

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DISCUSSION

Robert A. Scarborough, M. D. (Stanford University Hospital, San Francisco).—Doctors Burger and Torbert are to be commended upon their presentation of a method for extraperitoneal drainage of abdominal abscesses which should be an efficient weapon in the armamentarium of the abdominal surgeon. Its application, however, to the appendiceal abscess, and in particular to the retrocecal appendiceal abscess, warrants critical analysis.

In order more competently to dissent from some of their statements, I have carefully reviewed the forty-four cases of appendicitis with rupture and local or generalized peritonitis that have been treated in the Lane Hospital clinic of the Stanford Medical School and in my own practice during the past eight years. In twenty of these cases the appendix was entirely retrocecal.

The general principle of treatment in this series of cases has been immediate operation through a McBurney incision, removal of the diseased appendix, if this could be readily accomplished, drainage to the site of localized abscess formation if the pus had a distinct odor; or, if a stained smear of the pus showed more than occasional bacteria, drainage of the wound to the peritoneum only in cases of diffuse peritonitis, and in cases in which the pus was odorless and showed only occasional or no bacteria in a stained smear. In no case was the authors' method of extraperitoneal or delayed two-stage drainage applied.

Careful comparison of this series with that of the authors does not convince me that the application of their method to cases of retrocecal appendiceal abscess is of great value, and it appears even to have certain disadvantages.

In the authors' series of twenty-eight cases there have been no deaths. In our series of twenty cases there have been no deaths, a contradiction of the authors' figures of an expected mortality of 20 to 50 per cent. In both series the "postoperative course was smooth and convalescence rapid." In the authors' series only five out of twenty-eight had the guilty appendix removed at the time of operation. The other twenty-three patients presumably should have returned for subsequent appendectomy. In our series seventeen out of twenty had the appendix removed at the time of operation. One patient returned for interval appendectomy five months later, one delayed eleven months, and returned during another attack of uncomplicated acute appendicitis for appendectomy, and the third patient has not yet returned.

Further analysis of our twenty cases shows that ten had appendiceal abscesses localized entirely extraperitoneally, and might conceivably have been drained by the authors' method. But in the other ten cases, although the appendix was entirely retrocecal, the infection, proved by culture, had spread to a greater or less extent into the general peritoneal cavity. Clinical differentiation of the two types could not be made.

The point to be stressed is not the placing of drains which we know cannot drain the general peritoneal cavity, but the immediate removal of the source of further gross contamination so that the peritoneum itself can cope with the already existing infection. Any delayed method of drainage fails to accomplish this object.

A word of comment seems justified also upon the twenty-four other cases of nonretrocecal appendicitis in our series, with rupture and varying degrees of extension of peritoneal infection. Three deaths have occurred, all in patients with a generalized peritonitis in whom there was found, at operation, no effort whatever on the part of the omentum or viscera to wall off the infection. One of these patients died on the sixty-second postoperative day, and at autopsy was found to have had a thrombosis of the splenic vein with a septic infarct of the spleen and pyelonephritis. The peritonitis had entirely subsided. One patient died very suddenly eight hours after operation, presumably from an embolus. The third patient was operated upon on the fourteenth day of illness, and died on the twelfth postoperative day. Autopsy revealed an acute generalized peritonitis.

The operative mortality in the forty-four cases of appendicitis with rupture and all degrees of spread of peritoneal infection was 7.5 per cent. I do not believe this figure is exceptionally low. It would seem to bear out the contention that the continued high death rate from appendicitis is attributable not nearly so much to any failure of surgical technique, but much more to delay on the part of the patient with abdominal pain in calling his doctor, and delay on the part of the doctor in diagnosis and instigation of surgical treatment. It is the latter that must concern us most deeply. If and when the recognition of acute appendicitis can be improved and immediate surgical intervention employed, then and then only will there occur an appreciable drop in the mortality rate of this disease. The important factor is not the mortality in cases of appendicitis with rupture, but the high percentage of cases of appendicitis which are allowed to rupture.



Bon O. Adams, M.D. (Mission Inn Rotunda, Riverside).—Doctors Burger and Torbert have given us a very valuable method of treating certain classes of abdominal abscesses of difficult approach. They have reviewed the classification of abdominal abscesses with relation to their probable origin; as to peritoneal covered viscera; and as to approachability. They have shown that nature very deftly blocks off subjacent areas when an abscess is forming. This blocking-off process she does by creating an inflammatory area with plastic exudate, both choking off by adhesions and by "water logging" lymphatics, thus protecting neighboring areas and distant parts.

The doctors have very cleverly come to nature's aid when the abscess is so situated as to make its direct drainage difficult or dangerous to the general peritoneal cavity, and so to life. They have taken their cue from nature and extended her process by using vaselin gauze to induce adhesions, and lymphatic blocking instead of the plastic exudate and lymphatic water-logging and omentum which nature so valiantly throws about abdominal abscesses of whatever origin to protect the organism.

The authors have made a very valuable contribution by indicating a method of extending the protective process of blocking off dangerous and easily susceptible tissues in these abscesses that are not readily accessible without danger of contaminating subjacent tissues.

My friend, Dr. W. E. Gardner of Riverside, uses 1-1000 acriflavin gauze in a two-stage suprapubic prostatectomy operation to block the lymphatics of all tissues along the drainage tract. This gauze is packed into the first-stage wound down to the bladder wall and left for two to three days, when the gauze is removed, and the second stage of opening the bladder and removal of the gland is completed.

These conservative procedures are the development of mature surgical judgment, and are based upon well-established laws of tissue autoprotectability. Their employment will lead to the reduction in mortality statistics in a very hazardous class of cases.

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Joseph J. O'Hara, M.D. (233 A Street, San Diego).—Only complete agreement with the authors is possible in their conclusions that the mortality in abdominal abscesses is greatly decreased if extraperitoneal drainage is used.

I wish to add that I am sure that if a careful follow-up of all patients who have survived drainage of abdominal abscesses were made, it would be found that those patients in whom well-planned extraperitoneal drainage was used have far less difficulty later with troublesome adhesions and intestinal obstruction. I feel that a great many of the mechanical postoperative obstructions that we are operating upon are due to previous general peritoneal drainage.

I think most of us dislike two-stage operations and procedures that may require two separate incisions, as well as a procedure that has not satisfied us as to the actual origin of pus; the authors have outlined a treatment that disregards these feelings, but from their report it has certainly been very beneficial for their patients.

CRITICAL DECISIONS IN CATARACT SURGERY*

By Harold F. Whalman, M.D.
Los Angeles

Discussion *by Dohrmann K. Pischel, M. D., San Francisco; Otto Barkan, M. D., San Francisco; Dewey R. Powell, M. D., Stockton; K. C. Brandenburg, M. D., Long Beach.*

THE colleagues who are most stimulating to us are those who disagree with us. It is they whose ideas we should ponder, not that we may be converted by them, but that, in the light of their certainties, we may search out the basis of our own. We dignify by the name of beliefs a jumble of traditions and superstitions which need to be subjected to the careful scrutiny of scientific methods. Spurred by some skeptic, we finally sort out the grain from the chaff.

With this thought in mind the essayist has the temerity to present some ideas regarding the decision to operate several types of cataract.

The subject does not lend itself to statistical study, so that no statistics will be presented; but certain specific examples will be cited.

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

CONGENITAL CATARACT

Early surgery in congenital cataract depends on whether the condition completely obscures the vision, or whether the opacity is limited to the poles or nucleus. When complete it is best to operate as early as possible, even in the third month because, if delay ensues, central fixation will not develop and an ocular nystagmus will result.

In the incomplete cases the operation may be postponed for a considerable period of time, even into childhood.

Whenever operation is considered during the first year of life, it is advisable to take an x-ray plate of the chest to determine the presence of a persistent thymus gland before a general anesthetic is administered. Although a small thymus gland may be hyperactive, just as in a case of hyperactive thyroid gland, nevertheless one can at least determine the presence of an enlarged gland and, furthermore, the taking of the x-ray picture is sufficient to have some therapeutic effect upon the thymus itself. The anesthesia required, of course, need be only very brief, as the operative procedure itself is short. Even a local anesthetic can be used in these tiny mites.

In congenital cataract, of course, the needling operation is the one of choice, as it can be swiftly done, and autolysis will result.

UNILATERAL CATARACT

In connection with senile cataract, the surgeon is frequently confronted with the decision of whether or not to operate a unilateral cataract which has reached maturity.

In the first place, it is generally agreed that there is an optimum time to operate a cataract, and that is when it is matured. It is not desirable to wait until it has gone into a state of hypermaturity, where the percentage of good results is reduced thereby.

Removal of unilateral cataract offers the advantage of increasing the field of vision on the operated side, which is very important in these days of heavy pedestrian and vehicular traffic. I have never seen a case so operated that could not become accustomed to the visual disturbance that at first results from the disparity of images received upon the retina, provided the eye is not fitted with a full correction.

Thirdly, should there be a beginning cataract in the opposite eye, it is highly desirable to remove the mature cataract before the fellow eye becomes mature; because, when a patient is allowed to become totally blind, he neglects himself and becomes a less favorable physical risk thereby.

He also becomes psychologically a poorer risk. When the matured cataract has been removed, and there is a beginning cataract on the other eye, the patient feels that it can take its time getting ripe without any concern on his part.

There is also the cosmetic standpoint to be considered. A stary white pupil can be a source of social embarrassment and an economic liability.

COMPLICATED CATARACT

What shall be done, then, with complicated cataract? When it is known that systemic disease,

such as arteriosclerotic retinitis, healed albuminuric retinitis or diabetic retinitis, or other forms of chorioretinitis pathology, exists, the patient is entitled to whatever vision can be offered by virtue of a cataract extraction, even though this be of a very low acuity. The ability to perceive form alone is not only encouraging, but is valuable to the patient. However, one must emphasize to patient and relatives the limited results to be anticipated.

Liquid vitreous need not deter one from performing cataract extraction, as the loss of liquid vitreous is a much less serious matter than loss of normal vitreous. Many of these patients will retain useful vision for years, and since most of them are aged or infirm their life expectancy is not great anyway.

GLAUCOMA AND CATARACT

One sees from time to time cases of glaucoma associated with cataract in which one cannot be sure which has occurred first. If the history is of failing vision of short duration, and the refraction has changed to indicate an increased refractive index of the lens, then the elevated intra-ocular tension is probably due to a swelling of the lens, and cataract extraction will be followed by a normal tension. In one such case the writer performed a preliminary trephine operation in one eye which proved to be unnecessary, as the tension came to normal in the second eye following cataract extraction.

TRAUMATIC CATARACT

When traumatic cataract is the result of a penetrating injury and the lens is extensively injured, it seems best to remove as much of the lens substance as possible immediately upon seeing the case provided not more than twenty-four hours have elapsed. After that time, and when a reaction has commenced in the eye, it is better to wait until the eye has quieted somewhat before attempting to remove lens substance.

Dr. Edward Jackson has stated, in an editorial in the *American Journal of Ophthalmology* for December, 1935, that the chief value of two eyes is the service that one can render when the other is lost and, therefore, we should make every effort to save as much vision as possible in an injured eye. On the other hand, 2 per cent of perforating injuries of the eye result in sympathetic ophthalmia. Fifty per cent of these will get well. Although the risk is considerable when one realizes that with sympathetic ophthalmia both eyes may be lost, yet one never can tell when an injured eye which has been salvaged may be the only eye that the patient may have some time in his life because of some unfortunate mishap to its fellow.

DINITROPHENOL CATARACT

Since within the past eighteen months we have been called upon to make decisions regarding a new type of cataract requiring special consideration, I wish to mention some points in connection with dinitrophenol cataract.

Dinitrophenol cataract should be observed as early as it is possible to see the patient, watching the eye closely for signs of increased intra-ocular tension and acting to remove the lens when this occurs. It is true that some of the swelling of the lens will subside, but it is too dangerous to wait until this occurs, as an acute glaucoma may develop as a result, and I have seen one eye entirely lost, requiring enucleation as a result of complications which set in because it became an acute emergency situation.

When intra-ocular tension remains approximately normal, there is no great hurry about surgical intervention; but one should be guided by the extent to which the patient is incapacitated and, if possible, wait until certain disintegrating changes have taken place within the lens. In most patients under forty-five years of age, the embryonic suture lines will eventually be seen to be split wide open, and at that time one can perform a linear extraction without difficulty. The closer the patient approaches the age of fifty the less this can be done with facility, and the remainder of the cases operated should be done by the extra-capsular method. Intracapsular extraction is never advisable, because the zonule is usually resistant, while the capsule in these cases is particularly fragile, and one will not be successful in a large percentage of attempts. Furthermore, in every instance of dinitrophenol cataract that the author has had the opportunity to see, there has been an increased posterior segment pressure which makes one feel the need of the protection offered by the barrier composed of zonule and posterior capsule of the lens.

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DISCUSSION

Dohrmann K. Pischel, M.D. (490 Post Street, San Francisco).—In regard to congenital cataract, I believe that we all agree it is advisable to operate early so that the macula will develop, but not all will want to operate as early as the third month. Some might want to wait until one year. It would not be wise to wait longer. There are several conditions favoring early operation. The youngster is so small that he is easily controlled, takes an anesthetic easily, and postoperatively lies quite still. These are all advantages.

As to the operation itself, some would prefer a linear extraction where a lens is entirely opaque. By this means practically all the lens matter can be removed at once, and the convalescence is short. The annoying iritis, which frequently accompanies needling as well as any possibility of secondary glaucoma, is avoided.

In regard to unilateral cataract, I believe we must all agree with Doctor Whalman that it should be operated upon when mature, to prevent its progressing to hypermaturity. I feel that the difficulty of a cataract extraction is so much increased by this condition that the probability of success is greatly lessened. Furthermore, hypermature lenses are apt to become dislocated with all bad consequences of this condition.

The annoying postoperative diplopia, mentioned in the textbooks, is very rare indeed, although when present may be very distressing. On the other hand, I have had a patient who was only satisfied when he was wearing full correction of the aphacic eye, together with proper glasses over the unoperated eye.

Aside from the complicated cataract with fundus lesions mentioned by the author, is the cataract with healed cyclitic changes. Here, with many posterior synechia and thickened capsule, the intracapsular operation is the one of choice. But just when to operate is the more difficult question to answer. If vision is so poor as not to be useful, one can operate after the eye has been quiet six or eight months. When there is still quite useful vision left, the question comes up of operating with the possibility of improving the vision, on the one hand, or of stirring up a

devastating inflammation on the other. Here each case will have to be settled on its own merits.

In glaucoma with cataract, one should keep in mind the glaucoma stirred up by the flaking off of the anterior lens capsule, the "glaucoma capsulaire" of Vogt.

Under traumatic cataract, Doctor Whalman gives a rather high percentage of sympathetic ophthalmia. I have always felt that it was very rare, and this seems to be also borne out by the literature. However, the statistics on this subject are very variable, because few authors have had a chance to see a large number of cases. While many men go through a life's practice without encountering this distressing disease, it is just as well to have it always in mind so that one will not be caught unawares when such a case appears.

In regard to cataracts resulting from the use of dinitrophenol, I merely wish to report that a few weeks ago at Stanford Eye Clinic a patient was operated upon for just such a cataract. Apparently, the era of dinitrophenol cataract has not as yet ended.

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Otto Barkan, M.D. (490 Post Street, San Francisco). Most of us are, I think, agreed that more or less complete congenital cataracts, when present in both eyes, should be operated within the first few months of life. The choice of operation is still an open question. I should be interested to know Doctor Whalman's opinion of the relative merit of linear extraction, making the incision well within the cornea and very oblique, after a subconjunctival injection of adrenalin. The exquisite friability of the infant iris should be born in mind, and that the pupil is often difficult to dilate in this type of case.

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Dewey R. Powell, M. D. (242 North Sutter Street, Stockton).—We are indebted to Doctor Whalman for bringing before us this ever interesting problem of what course to follow in certain types of cataract.

The title, "Critical Decisions in Cataract Surgery," is most apt, as both the fate of the eye and the peace of mind of both patient and surgeon depend on the wisdom of the course adopted. In his opening sentence, Doctor Whalman invites discussion through disagreement, but I find myself quite in accord with the procedures outlined and can only concur in the decisions arrived at, except in the question of the treatment of unilateral cataract. I am fully aware of the oft-quoted dictum of Knapp, "Get all the vision you can when you can," and I know that the usual advice given is to operate. If there is a beginning cataract in the other eye, there can be no question as to the advisability of operation, but if there is normal vision in the good eye, I am very hesitant about suggesting any removal of the cataractous lens.

I have had two patients who, in spite of correct postoperative vision of 20/30 and 20/20, respectively, had such confusion due to inability either to fuse the unlike images or suppress one of them that they only had comfort when one eye was covered. This was true with only a weak correction on the operated eye and even without a correction. This disparity of images was so annoying that I have since followed the custom of watchful waiting in cases of unilateral cataract with normal or nearly normal vision in the other eye. The situation is explained fully to the patient, who is asked to report for regular check-up examinations so that any new developments can be appropriately met. In all other decisions, I am in accord with the essayist.

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K. C. Brandenburg, M. D. (110 Pine Avenue, Long Beach).—We are indebted to Doctor Whalman for his presentation of the affirmative side of the question, when to operate. Most of us are aware of a number of reasons which may well decide us against operation in the cases which Doctor Whalman feels should be submitted to surgery. These considerations are not only of a purely ophthalmic nature, but are physiologic and economic as well.

The skill of the operator, as reflected in his results, must also be a determining factor in deciding whether the probable benefits will outweigh the risks which are an inevitable accompaniment of all surgery.

AS A PHARMACIST VIEWS THE PROPOSED CALIFORNIA HUMANE POUND LAW*

By James J. Boyle
Los Angeles

THE prejudices against animal vivisection remain one of the most serious obstacles to the progress of medicine, surgery, and pharmacology.

The Humane Pound Law being sponsored as an Initiative on the November, 1938, ballot will aid to intensify that prejudice.

To the general public the "Humane Pound Law" is a misnomer. The sponsors should come out in the open and call the Initiative by its proper name, "Antivivisection Act." The mothers and fathers of California must be warned of this deception of an apparently harmless title.

We pharmacists have witnessed before now many attempts to regulate, control and perhaps prevent the advancement of research in medicine. A similar proposal appeared on the ballot in 1922. It was defeated overwhelmingly. At each successive session of the California Legislature, except 1937, attempts were made to compel the Legislature to pass such a law. Every conceivable method known to modern lobbying was used; money was spent freely, threats and intimidations were employed, but the Legislature, in its wisdom, saw otherwise.

Should this proposed Initiative Act become the law of California, the education of pharmacists and of physicians and scientists would be superficial. Our knowledge of metabolism, the physiology of the digestive tract, came largely through animal experimentation and research on dogs.

Bacteriology, part of a pharmacist's education, is most essential to us if we are to continue to perform as the physician's right-hand man. The appreciation of the theory of immunology is essential in our daily work of dispensing serums and vaccines.

We are only too familiar with the noble results shown by public health records of the value of diphtheria, typhoid, scarlet fever, antitoxins, and antirabic inoculations, as well as the vaccines of smallpox and tuberculins. We are the guardians of biologics, kept under proper refrigeration, subject to emergency calls from physicians, night and day.

Antivivisectionists might well pause for a moment and give thanks that animal experimentation has saved the lives of thousands of children against infectious and contagious diseases. Yes, and also saving the lives of their pets as well.

We, as pharmacists, appreciate the economic saving to the nation that insulin has been the means of effecting. Since the discovery of insulin, men, women, and children are assured of a normal span of life. Diabetes is no longer the dreaded, incurable disease we formally knew. Insulin research has

* Read at a joint meeting of the Los Angeles County Medical Association and the Southern California Retail Druggists Association at Los Angeles on March 17, 1938.

See also editorial comment, on page 236.

played a dramatic part in this economic saving, due through experiments on dogs. Daily it is my pleasure to dispense insulin to many prominent and active citizens whose families would suffer not only an economic loss, but companionship and love for many years to come, did we not possess this beneficent research discovery.

Materia medica is a much different subject today than when I studied pharmacy. We pharmacists discuss many new potent drugs with our physicians. Without animal experimentation these new potent and specifics would not be available. Local anesthetics, digitalis derivatives, and heart problems are now fairly well controlled because of proper standardization. Chenopodium has done its part in the elimination of hookworm. Viosterol and our vitamins A, B, C, D, G, and K, are today household words given to parents by the pediatricians. Rickets, malnutrition, and dental problems are daily solved and, here again, largely because of animal standardization. Parents expect the pharmacist to guide them intelligently in their selection of vitamin products.

The pituitary extracts—Are we to be denied their continued use? For only through animal experimentation can the flow of such essential drugs pass from our great pharmaceutical laboratories, hospitals, and pharmacies to mothers, guaranteeing safe childbirth. I can well recall when the strengths of pituitary extract on the market varied from a ratio of one to eighty; what a sigh of relief, therefore, must come to every physician and pharmacist on dispensing potent drugs today, which, because of research on lower animals, standardization is much more exact.

Pharmacists look with optimism into the practically unknown field of endocrinology. Perhaps today we are facing a world of marvelous discoveries yet to be found. Our position in this field is comparable to chemistry about one hundred years ago. Only through animal experimentation can we continue to explore this most fascinating field of medicine that has given us the estrogenic products and the various glandular substances and extracts with which the pharmacist, as well as the physician, must now familiarize himself.

If we are to eradicate cancer, man's most perplexing disease, it will be accomplished, in part, through animal experimentation. Certainly it is not the intention of many of the most intelligent, but misguided citizens, to lend a hand at blocking this humane study. Surely, this group do not ask that cancer be eradicated only by experiments on their brothers and sisters.

We pharmacists have joined hands with the physician, research workers, and public health officials in spreading the gospel of health through constructive educational programs, based on facts of accomplishment. The lives of the pharmacist, Pasteur, and the physician, Jenner, still remain, and should continue, for all of us, guiding stars in overcoming disease in both human beings and the lower animals.

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PROPOSED CALIFORNIA HUMANE POUND LAW: HOW IT WOULD AFFECT MEDICINE AND PHARMACOLOGY*

By Clinton H. Thienes, M.D.
Los Angeles

Discussion *by Fred B. Moor, M. D., Los Angeles.*

Sir William Osler makes the statement that, in the more than two thousand years from Hippocrates to Jenner, less was done to emancipate medicine from the routine and thraldom of tradition than was accomplished in the second half of the nineteenth century by experimental medicine.[1] The Hippocrates to Jenner era was one of observation of uncontrolled phenomena of disease. The era since has been characterized by the rise of the experimental method, so ably championed by Claude Bernard seventy-five years ago. What is the experimental method? It is the method of the controlled testing of scientific concepts. The experimental method in medicine requires living beings; that means animals or human beings. Surely, the life or liberty of neither animal nor human being may justifiably be placed in jeopardy unless, by so doing, many more animals and human beings are benefited, and to a great degree. Is this the case?

KNOWLEDGE OF LIVING TISSUE ESSENTIAL

First, let us consider the training of the student of medicine. As a practitioner, he must deal with living tissues. One of the best preparations for this is to learn what living tissue is. To this end he is trained by means of experience with living animals. And the student must learn the mechanisms of drug action. Such functions and mechanisms cannot be taught on the human being nor upon dead men or dead animals, but must be learned through analytical studies on living animals. Such analytical studies usually require operative or painful procedures. Hence, the animals are anesthetized to prevent such pain. If for no other reason than to create in the student a desire to relieve pain the teacher of medical science would see to it that the animal is spared unwarranted suffering. Medical education has advanced with great strides since, and largely because of, the introduction of the experimental method in the teaching laboratory. The use of animals, then, is of great importance for the training of the doctors of the future. But the most impressive value of the use of animals in relation to medicine is in the study and control of disease.

DIPHTHERIA'S DEATH TOLL, HAD THERE BEEN NO ANIMAL EXPERIMENTATION

As examples, I wish to select but a few of many that might be chosen. Let us consider, first, diphtheria. Diphtheria has been largely a disease of children and, in its fatal form, a very painful and terrifying malady, with death by slow suffocation.

In New York City, the average number of deaths per year from diphtheria during the seventeen years 1878 to 1894 was 144 per 100,000 popu-

* Read at a joint meeting of the Los Angeles County Medical Association and the Southern California Retail Druggists Association in Los Angeles on March 17, 1938.

See also editorial comment, on page 236.

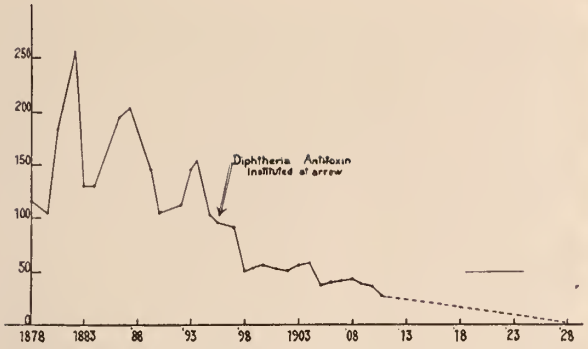


Fig. 1.—Diphtheria mortality 1,000,000 per year (by years).

lation. In 1894, the antitoxin laboratory was established in the city. From 1895 to 1911, which is the first seventeen years after the institution of antitoxin treatment, the yearly average number of deaths was but fifty-four.[2] Chart 1 indicates the trend during these years. Since 1911 the trend has continued downward, due to more widespread use of antitoxin, earlier diagnosis and immunization of school children; and, according to Park,[3] the figure for New York City not long ago was but four per 100,000. All writers consulted state that the mortality among cases treated during the first day of the disease is nil, and that for all treated cases it is less than 9 per cent, while of cases which do not receive antitoxin, over 30 per cent die.

This remarkable decrease in diphtheria mortality would have been impossible without animal experimentation which made the discovery of antitoxin possible, and, furthermore, the preparation of antitoxin today would be impossible without the use of the laboratory animal, which is the source of the antitoxin. All antitoxins and antisera are prepared by injecting the toxin or vaccine into the laboratory animal, usually the horse, and the subsequent bleeding of the animal to secure the serum which contains the antitoxin. Anyone seeing the sleek animals, living in animal luxury, from which blood is periodically drawn in the preparation of the antitoxin, must admit that the animal shows not the slightest evidence of torture.

RABIES: PASTEUR'S BENEFICENT SERVICE TO THE HUMAN RACE

Another infectious disease conquered by animal experimentation and by the use of animals for the preparation of the medicinal material, is rabies (hydrophobia). In all my medical career I have seen but one case of human rabies. This was a child of eighteen months, whose pitiful condition left its image ineradicably in my memory. Figures 2 and 3 show a young man in the terminal stages of rabies. In contrast to this is the instance of a medical colleague of mine who bears many scars from an encounter with a rabid dog, and who has escaped the horrible death by rabies because of the work of Pasteur. Before the institution of the Pasteur treatment, every medical student was familiar with the disease at first hand, because 15 per cent of the victims of rabid dogs succumbed to the disease. Now the Pasteur treatment has reduced the incidence of this universally fatal malady,



Fig. 2.*—Patient (rabies) in enclosed enclosure. Photograph taken in pause between two attacks. (Difficult breathing, complete exhaustion.)

so that of over five thousand persons in New York City who have been bitten by infected animals, only twenty (0.4 per cent) have died.[4]

Not only are thousands of human lives saved by antirabies treatment, but thousands of valuable or cherished dogs are yearly inoculated with the vaccine either as treatment or as an immunization against hydrophobia.

It is the lowly rabbit which supplies us with the Pasteur vaccine. The virus, which has been attenuated by passing through a series of rabbits, is inoculated into the final rabbit. After a certain time the rabbit is killed and its central nervous system is employed in the preparation of the therapeutic vaccine.

Who is there among you who would care to weigh the life of a child or of an adult person against that of a rabbit? And who among you can call it cruelty to sacrifice the animals for such purposes?



Fig. 3.*—Invalid during an attack of hydrophobia. Anxious, distressed expression of countenance, fixed gaze, divergent strabismus, laryngical spasm.

* Figures 1 and 2 taken from monograph, "Lyssa bei Mensch und Tier" by R. Kraus, F. Gerlach und F. Schweinburg. Published by Urban und Schwarzenberg, Berlin and Wien, 1926.



Fig. 4.



Fig. 5.

Fig. 4.—Diabetic child on admission to the clinic before treatment.

Fig. 5.—The same child as in Fig. 4, one month after treatment with insulin.



Fig. 6.

Fig. 6.—Group of diabetic children (after treatment with insulin). Photograph taken in 1927.

DIABETES: ITS MORTALITY RATES IN FORMER AND PRESENT DAYS

A third condition in which thousands of lives have been saved by animal experimentation is diabetes mellitus. Most of you remember the pre-insulin days. Diabetes was one of the dreaded diseases. In the young it was rapidly fatal. Few children lived more than a year after the onset of the disease, and the average length of life of a twenty-year-old patient was two years or less. What miserable folk they were: thin, weak, sallow, cold, hungry and thirsty, waiting for death (Figure 4). Today a diabetic can live a nearly normal life, except for the carefully adjusted diet and the daily injections of insulin. His life expectancy is almost that of a nondiabetic. This change in affairs has come about through animal experimentation and would have been impossible otherwise.

In Figure 5 we see the same child as in Figure 4, just thirty-four days after insulin treatment was begun. The photograph shown in Figure 6 is of a group of children at a local diabetic Children's Clinic in 1927. Today two of the girls are mothers, one of the boys is an assistant professor of chemistry and, except for a boy who died of bone sarcoma and a girl who died of lung abscess, all are living useful lives. Without insulin, none of these children would be alive today.*

The dog has been the only animal that could be transformed into a chronic diabetic for the careful study of the various factors in diabetes mellitus and for the study of the actions of insulin in the diabetic animal.

You may say that we have now gained so much knowledge of diabetes that further sacrifice of animals is unwarranted. But if the use of animals for scientific purposes were to cease, insulin standardization would be impossible, for we have no chemical criteria for its assay. Thousands of rabbits are necessary for the determination of the potency of the various batches of insulin prepared in this country. Insulin is a very potent material, and its dose must be accurately adjusted to the needs of the individual patient. Without standardization of potency, a patient might either be excreting large amounts of sugar, or be in a state of insulin shock. An overdose of insulin can be a very dangerous episode in the life of the diabetic patient. First judgment, then muscle control, then consciousness is lost, and convulsions supervene. Patients would not dare venture out of doors if they could not feel reasonably sure of a given volume of insulin solution producing a uniform effect. This uniformity of effect could not be without animal control of the insulin potency.

SMALLPOX, LOCKJAW, BUBONIC PLAGUE, SYPHILIS, AND OTHER DISEASES

I have mentioned but three of the triumphs of experimental medicine. I could tell you of the conquering of smallpox, lockjaw, plague, and syphilis; of great advances in our knowledge of infantile paralysis, tuberculosis, and pneumonia. I could relate recent experiments which seem to open wide the gate that has kept us in ignorance of the mechanism of high blood pressure. I could show how animals are indispensable for the establishment of the mechanisms of drug action and for the control of the potency of digitalis, ergot, pituitary extract, and many other potent drugs. How, also, the new anesthetics, ethylene and cyclopropane, were discovered through animal experiments; and how this marvelous new drug, sulfanilamid, which is doing such remarkable things in the treatment of childbed fever, streptococcus wound infections, and acute epidemic meningitis, was first brought to

* We are indebted to Drs. Bertnard Smith and Howard F. West, of Los Angeles, for these photographs.

light by tests on animals. But because neither my time nor your patience permits this, I must content myself with presenting a prophetic picture. Until we learned how to produce cancer in experimental animals, we learned but little about the characteristics of malignant tumors. Then it was learned that tar cancer could be produced in rabbits, that a tumorous growth could be initiated in fowl by the injection of a specific virus, and that spontaneous tumors could be transplanted from one animal to another. This led to the discovery of the carcinogenic sterols, to the discovery of genetic control of experimental cancer and, finally, to the rôle of the hypophysis and of the ovary, in the regulation of the growth and incidence of experimental malignant tumors. If one may forecast the future, on the basis of past experience, one may feel justified in believing that, before long, through animal experimentation, this disease of old age may be conquered. Having conquered many of the diseases of youth, we lengthen life into that era where cancer and circulatory disease take their toll. Most of those in this room will fall victim to one or the other. We are well on the way to understanding both through animal experimentation. We must not turn back. We must not even stand still. We must go forward.

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DISCUSSION

Fred B. Moor, M.D. (White Memorial Hospital, Los Angeles).—Doctor Thienes has presented to you a most convincing argument for the humane use of animals in the study of disease, the development of biological remedies, and the elucidation and standardization of drug action. It seems incredible that any but the most uninformed or wilfully ignorant would seek to impede medical progress in the life and death struggle with devastating diseases.

Although the past fifty years have witnessed wonderful progress in the control and treatment of disease by the aid of animal experimentation, medical frontiers are not yet abolished. New regions are constantly opening up, for example, the rapidly developing fields of nutrition and endocrinology, both of which require the use of animals in the solution of a multitude of unsolved problems. The discovery that nicotinic acid produces a most spectacular cure of pellagra arose from the observation that it relieved the black tongue disease of dogs. This discovery benefits both dogs and men, as do many of the results of animal experimentation. The control of pernicious anemia by the use of specific liver and stomach extracts had its foundation in the fundamental observation of Whipple that liver-feeding was especially effective in curing experimental anemia in dogs. As Doctor Thienes has intimated, one can continue indefinitely enumerating steps in medical progress which have been based directly or indirectly upon animal experimentation.

Let us suppose for a moment that the dreams and desires of certain well-meaning but misguided people could be realized, and that all animal experimentation could be abolished. Smallpox would again become epidemic as it has been in the past, and as it is occasionally still in some unvaccinated populations. Diphtheria would again become a prevalent disease and would exact a death toll of 30 per cent of its youthful victims. Typhoid fever and tetanus would again ravage our armies in time of war. Diabetics would again be consigned to their miserable state of preinsulin days. The mortality, which in nearly half of all lobar pneumonias can be reduced by specific serum to 10 to 20 per cent, would again rise to from 30 to 40 per cent. As Doctor Thienes has pointed out, we would be forced to use certain drugs of unstandardized potency. I was told recently that our local health department, most of the time, has under treatment several persons who have been bitten by rabid dogs. Without the Pasteur treatment these individuals would be waiting in awful suspense wondering if and when symptoms of rabies might appear, and when they did appear if nothing could be done about it. Our children would be exposed daily to attacks of rabid animals; and even the very animals which the proposed so-called Humane Pound Law seeks to protect would be in danger of much worse suffering than being painlessly put to sleep in an experimental laboratory with an anesthetic, to serve a merciful purpose in the study of means for relief of both animal and human disease.

Such would be the situation if we were denied the use of animals for experimental purposes. Surely, the people of California, if they knew the truth, would not desire even to take this first step in the abolition of the use of animals in experimental studies which will save the lives of their children.

FEDERAL AND STATE NARCOTIC LAWS: CAUTIONS FOR PHYSICIANS*

By William R. Molony, Sr., M.D.
Los Angeles

A BRIEF outline of major points on the narcotic laws include items such as follow:

The narcotic regulations that affect the physicians and surgeons of California come from two sources, namely, the Federal (Harrison Narcotic Law) and the State (Division of Narcotic Enforcement Government). It is quite important that each practicing licensed physician be familiar with the basic regulations of these laws.

At the present writing there are about one hundred licensed men under probation from the Board of Medical Examiners, and at least 75 per cent of these may trace their trouble to a violation of these narcotic laws.

Occasionally we find that a doctor gets into difficulty through carelessness or a misguided desire to help out an "addict" in his misery; but most of the cases develop from a deliberate violation of these laws, either in prescribing for a fee or the sale of narcotics to "addicts." No good ever comes from these practices, and the sooner our physicians stop writing for these habitual users the better off they will be.

A habitual user may be one who started with or still has a definite pathology; but no "pathology" requires 15 to 20 grains of morphin a day. The most severe type of pain is ordinarily controlled by a grain of morphin, and the balance of the daily dose is simply to satisfy the addiction.

The agents of the Federal and State narcotic enforcement divisions are anxious to coöperate with the medical profession. In most cases, after an investigation they settle the case with a word of caution, and an explanation of the law. It is only the doctor who is a "repeater" and one who is writing for "addicts" or selling narcotics who is arrested and punished.

* See also editorial comment, on page 236.

If a doctor has a bona fide patient under his care that requires morphin, he may order as much as in his judgment is needed; but he must have made his own independent diagnosis and thereafter notified in writing the proper enforcement office. If he follows this procedure, he has but little fear of being molested.

Ambulatory treatment of narcotic addiction is prohibited. "A physician cannot treat a case of narcotic addiction in a patient's home. The treatment must be given in a hospital or institution approved by the Board of Medical Examiners, or in city or county jails, where the patient is at *all times under restraint and control.*"

"That such addict is kept under restraint or control is the essential requirement for approval. Narcotics can *only* be administered to an addict under treatment in such an approved institution by a *licensed physician and surgeon* or a *registered nurse* acting under his direction."

"Narcotics may be prescribed in *good faith* for a *reasonable time* and in *reasonable amounts* by a duly licensed physician and surgeon to his patient for any disease, ailment, or injury, other than narcotic addiction. Such physician and surgeon must keep an office record, giving the name of the patient, the pathology for which each treatment is given, and the date thereof. This record is open to inspection by the officers of the law."

The first pages of the directory, issued yearly by the Board of Medical Examiners, a copy of which is sent to every California licentiate, is devoted to a full and clear explanation of the narcotic regulations.

1930 Wilshire Boulevard.

FEDERAL AND CALIFORNIA STATE NARCOTIC LAWS*

CAUTIONS FROM THE STANDPOINT OF A PHARMACIST

By Frank Homer
Beverly Hills

I will try to point out some of the differences in the new State Narcotic and the Federal Narcotic Acts. A new California law (Senate Bill 62) was enacted at the last session of the Legislature as an amendment to the State Narcotic Act. It strengthens the present Act, and imposes certain new restrictions not contained in the old measure. There are several new departures in this Act, some of which exceed the Federal statute in the things a doctor or druggist is required to do. It is extremely important that you fix these things in your mind to properly comply with both State and Federal Acts.

RECENT AMENDMENTS TO THE STATE NARCOTIC LAW

The first and most important change in the new Act is the entire elimination of any preparation containing any narcotic other than codein from the exempt narcotic list. This means that any preparation containing morphin, heroin, opium, or any of the salts or derivatives of these cannot be sold, even though the narcotic ingredient is present in the minutest quantity, except on a doctor's prescription; syrup of cocillana compound, elixir of copevine and a number of preparations containing ethyl morphin, hydrachlorid (or dionin) can only be dispensed on a doctor's prescription. In other words, codein is the only narcotic now permissible in exempt preparations in the State of California. And the quantity, one grain per ounce, still remains. Here are some of the essential differences in the present act:

The Federal law does not specify any time at which the prescription may be filled after it is written.

The new State law specifies that no prescription can be filled later than the seventh day after it has been written. And that no prescription can be postdated or antedated. The Federal law does not prevent the giving of a copy or duplicate of a narcotic prescription, the same marked across the face plainly, "copy." The new State law specifically makes it unlawful to give any copy or duplicate of any prescription except to an inspector of the Board of Pharmacy or to the chief inspector of the narcotic enforcement division. The Federal law permits a prescription to be dictated to another person or to be typed by an office assistant if it is properly signed by the doctor. The State law specifies that any narcotic prescription must be wholly written, signed, and dated by the person writing the prescription. These are the essential and principal differences. And where the State law is stronger than the Federal statute, the State law takes precedence.

All narcotic prescriptions must have the date, patient's full name, street address and city or town in which he lives; also, the doctor's full name, street address, city and registry number.

A narcotic prescription that has been altered or changed in any respect cannot be filled by the pharmacist.

Now, with reference to the writing of narcotic prescriptions calling for preparations which have previously been on the exempt narcotic list, the chief inspector of the narcotic enforcement division has stated that in the absence of any regulations yet received, the law will be enforced as written. And that means that a prescription, for instance, written for cocillana compound, would have to be wholly written in the doctor's own hand and presented in the same form as a narcotic prescription, nor could the prescription be refilled or a copy given. In other words, this prescription would take the same procedure as a prescription calling for morphin tablets.

In closing, I should like to see the doctors and druggists some day go on record condemning the practice of selling drugs and medicines through any other channels than the regularly licensed pharmacy. A proper law could go far in doing away with house-to-house peddling of drugs and medicines, and other forms of selling that lead to self-medication, and worse.

449 North Canon Drive.

* Read at a joint meeting of the Los Angeles County Medical Association and the Southern California Retail Druggists Association in Los Angeles on March 17, 1938.

See also editorial comment, on page 236.

THE LURE OF MEDICAL HISTORY†

HUGH HUGER TOLAND*

GREAT PIONEER SURGEON AND FOUNDER OF THE MEDICAL SCHOOL OF THE UNIVERSITY OF CALIFORNIA

VI

By Edgar Lorrington Gilcreest, M.D.
San Francisco

PART I**

IN this age of scientific achievement, it is well occasionally to look backward and take note of what some of the pioneers in medicine and surgery accomplished and gave to our craft. Hugh Huger Toland was one of these, and his contributions to surgery were far-reaching.

Born on a plantation at Guilders Creek, Newberry County, South Carolina, on April 16, 1806, in the cradle of Southern culture and chivalry, he was the fourth child in a family of ten. On his father's side he was of Irish descent, his ancestry being traced in a direct line to John Toland, a native of Londonderry, who, early in the eighteenth century, was the confidant of Harley, the Earl of Oxford, and was known to the world of letters and politics as an author and politician of repute. His father, John, a virile character, born in Newton Stuart in the north of Ireland, emigrated to America, where he became a wealthy planter and banker, and was highly respected in his community. His mother, Mary Boyd Toland, of Scot descent, was a remarkable woman—keen, alert, and an excellent manager of business and household affairs. She had considerable executive ability. The happy blending and influence of these two racial streams can be observed throughout Toland's long, vigorous, and productive career.

A PRECOCIOUS CHILD

A precocious child, Hugh was sent to school when but a little more than four years old, and at the age of six won first prize for reading in a class of forty children, many of whom were his seniors. Although educational opportunities were limited in that community, he acquired a good education and a knowledge of Latin and Greek, which proved of considerable benefit to him in his medical studies. He was in every respect an all-round, normal boy. He was very fond of athletics, and after many severely contested combats, became the best boy pugilist in Newberry County.

UNDERGRADUATE DAYS

Banking as a life work had no attraction for young Toland and, consistent with the custom in those days, at the age of sixteen he began his medical studies in the office of the most distinguished physician in South Carolina, Dr. George Ross. He remained under Doctor Ross's tutelage for eighteen months, and also helped in the Doctor's drug store, which was combined with his office.

MEDICAL EDUCATION

By this time Hugh's father, who had intended him for the study of law, became convinced that medicine was his son's calling. Accordingly, he was permitted to go to the University of Transylvania in Lexington, Kentucky, which had the distinction of having the first medical school to be organized west of the Alleghanies. There, in 1828, at the age of twenty-two, he was graduated in medicine at the head of a class of 160 students.

PRELIMINARY MEDICAL PRACTICE

The following year he began practice in Reeders, near Newberry, South Carolina. By nature bold, courageous, and resourceful, he soon successfully executed several important operations, and his reputation was immediately established in that community. His services were in great demand, and he often rode seventy or eighty miles a day on horseback in making his rounds of calls. His practice flourished, so that at the expiration of two years of country practice he had saved $2,700. He then returned to the medical school in Lexington, where he spent the winter in dissecting and in studying French.

EUROPEAN STUDY

With his tidy savings, and encouraged by his surgical achievements, he was then able to carry out his heart's desire—to go to Paris for further training. For the next two and one-half years he studied under such surgical and medical masters as Baron Guillaume Dupuytren, Jacques Lisfranc, Philibery Joseph Roux, Armand Trousseau, and others. There he met a notable group of American students, among them George Washington Bethune, Henry Ingersoll Bowditch, and Oliver Wendell Holmes, of Boston; and William Wood Gerhard, William Pepper and Joseph Peace, of Philadelphia. While in France he rendered valuable assistance during the epidemic of Asiatic cholera that decimated the country in 1833.

MEDICAL PRACTICE IN SOUTH CAROLINA

In 1833, Toland returned to Newberry County and resumed practice. One day, as he stood in the country drug store of his town, his mind on the teachings of Trousseau, a man staggered in, cyanotic, gasping, and eyes bulging. He was choking to death with quinsy. Toland, instantly recognizing the danger, put him in a chair, seized his instruments and was about to perform a tracheotomy when physicians who were present objected to such a radical procedure, and before Toland could convince them of its necessity the patient died.

Disgusted with the shortsightedness of his colleagues, Toland moved to Columbia, where he formed a partnership with Dr. Thomas H. Wells.

† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

Read before the Historical Section of the San Francisco Medical Society, January 11, 1938.

This is Paper VI of the series. For other articles in the symposium, see California and Western Medicine, November, 1937, page 321; December, page 405; January, page 27; February, page 114; March, page 186.

** This paper, on Hugh Huger Toland is printed in two parts—Part I in April issue; Part II in May number.



Fig. 1.—Hugh Huger Toland, 1806–1880. Founder of Toland Medical College, 1864. Toland Medical College became affiliated with University of California in 1873.

There he married Mary Goodwin, a direct descendant of Pocohontas, but she lived only a few years. In 1844 he married Mary Avery, who bore him two daughters. Toland became a dominant surgical leader in Columbia, and achieved both professional and financial success. He performed operations for the relief of club-foot and strabismus, and his method of using the lithotomy forceps soon spread beyond his state, and as early as 1841 arrested the attention of no less a surgical master than James Marion Sims of Montgomery, Alabama. It is reported that during this period Toland did as much work as all of the other doctors in Columbia combined, and that his annual income was $16,000.

LURE OF CALIFORNIA

Then came news of the discovery of gold in California. Although Toland was forty-six years of age, the spirit of adventure was still strong in him, and he could not resist the call of the West. So, in 1852, he left his lucrative practice, and he and his wife began to cross the plains with a party.

He entertained little doubt that success again awaited him in new fields. His confidence in this was based, first, on his knowledge that his reputation as a surgeon had preceded him and was known to many Carolinians then living in California; secondly, on his financial status, which made him economically secure for a long time; and thirdly, on the fact that he had shipped to California a quartz mill with which he hoped to make a fortune from the precious metal. This mill was one of the first to reach the State.

His party crossed from Independence, Missouri, to California in seventy-six days, breaking the record at that period. Three days after their arrival his wife died at Stockton. Immediately after arriving there he went to Calaveras County and bought the Gwin mine at Lower Rich Gulch, seven miles from Mokelumne Hill.

EARLY DAYS IN SAN FRANCISCO

After three months Toland realized that mining was neither to his taste nor his profit, and that a doctor should stick to his profession. So he sold his mine.* Saddened by the death of his wife and discouraged by the loss of a great part of his capital, but still resolute, he moved permanently to San Francisco in 1853 and gave himself over wholeheartedly to his profession. He soon attained wide popularity, and advanced steadily to fame and fortune. For twenty-seven years, even to the day of his death, he played a leading rôle in the practice of surgery, as one of the most distinguished surgeons in the West. He became widely known as "the great surgeon of the Pacific Coast." On October 6, 1860, he married Mrs. Mary B. (Morrison) Gridley of San Francisco, a woman of education, with a local reputation as a poetess and painter, who bore him one son.[1]

ACQUIRES A LARGE AND LUCRATIVE PRACTICE

His spacious offices, located at Montgomery and Merchant streets from the time he began practice in San Francisco until his death, were always filled with patients. The large number of persons waiting in his reception room gave it the appearance of a great out-patient clinic, and frequently it became so crowded that some had to wait outside on the steps. It is estimated that he saw about a hundred patients a day in his office, and made from forty to fifty visits in addition. Sunday afforded him little rest. He was a picturesque figure as he made his visits about San Francisco. This was the day when a physician was known for his equipage, and Toland rode in an old-fashioned buggy with a negro driving two handsome horses. Within two years of his arrival in San Francisco he is reported to have been making $20,000 annually from his practice. This shortly rose to $42,000. Soon after the Civil War began, however, California went on the Northern side and, because Toland was an ardent Southerner, his influence naturally became less and his income diminished. As there was no one with equal ability to take his place, however, he was soon as busy as before.

INTEREST IN ORGANIZED MEDICINE

This was the most productive period of his life. In 1855, two years after beginning his practice in San Francisco, he was appointed chief surgeon to the Marine Hospital, a position which he held for many years. Ten years later, he was appointed visiting surgeon to the City and County Hospital, and also a member of the first Board of Health of San Francisco, a connection he retained until his death. For ten years he was the proprietor of

* I am informed that since then over six million dollars in gold have been taken out of this mine, and that it is still not worked out.

the *Pacific Medical Journal,* which, in 1872, was renamed the *Western Lancet.*

A FAMOUS CONSULTANT

In 1856 he played a leading rôle as surgical consultant in the famous and fatal illness of James King of William of San Francisco, whose death. as the result of an assassin's bullet, so shocked and electrified the community, and so aroused public opinion, that the San Francisco Vigilantes took charge of affairs and caused the restoration of law and justice.[4] The question of whether or not a sponge,† which had been inserted in the wound after the shooting, should or should not have been removed became a great issue after King's death, not only in the medical societies but in the courts. It was truly the talk of the town. The controversy raged between Toland and Cole, and the newspapers made front-page news out of it. R. Beverly Cole, a medical leader as fiery and dynamic as might be expected from his Virginian birth and Kentucky rearing, testified in the trial "that the pressure of the sponge and the pressure of the tourniquet induced phlebitis and caused King's death." He also made remarks reflecting on Toland's reputation. Toland, however, in his testimony "confined his evidence strictly to the case in hand and made no personal remarks against Cole. He claimed he left the sponge in the wound because there was no left pulse and he feared the subclavian artery was severed or injured and would rupture or slough; that the wound caused a lesion of the vein and injury of the nerves in the vicinity; that, as a consequence, inflammation of the chest and inflammation of the vein followed and death ensued."

TOLAND MEDICAL COLLEGE

By 1864, near the close of the Civil War, Toland realized the fulfillment of a wish he had long cherished, which was the founding and erection of a medical school, known as the Toland Medical College.[2] At his personal expense a handsome brick and stone building was constructed on Stockton Street, between Chestnut and Francisco streets, and it was supplied with all the necessary appliances consistent with a thoroughly equipped medical school of that day. Toland was president of the faculty and professor of surgery. In spite of the bitter controversy between him and Cole eight years before, when he organized his medical school, Cole was made dean. At the beginning, the school was eminently successful and received the confidence of the public; but six years later, in 1870, a split occurred in the faculty which led to the formation of the Cooper Medical School. When several of the important members of his faculty left him, they took all the students but one. Failing in his efforts to get his colleagues or his students to return, three years later he unconditionally donated his school, with its furnishings and the land, valued at approximately $100,000, to the regents of the University of California, and it became an integral part of that university.[12] The faculty retained its membership, and Toland remained the professor of surgery until his death. His school had added a stimulus to the medical education of its day, and had given many men an opportunity which otherwise they would not have had.

† "The Sponge—Its Effect on the Martyrdom of James King of William, The Formation of the San Francisco Vigilance Committee of 1856, The Execution of Casey and Cora for Murder and the Trial of Edward McGowan for Complicity," was made the subject of an interesting article by Dr. George D. Lyman in 1928.



Fig. 2.—Toland Medical College, 1864.

A COMMANDING FIGURE

Toland was a commanding figure, well over six feet tall, erect, and dignified. Strength and forcefulness were evident in the straight, well-shaped nose, the prominent, determined lower jaw, the dark blue eyes, so discerning and keen, yet so kindly. His finely shaped head was covered with jet-black hair which fell almost to his collar, and his high forehead gave unmistakable evidence of the degree of his intellect. His carriage and every movement showed power and purpose. Delicate sensibility, a refined sense of honor and strict integrity were evident. Even his dress—the large, soft hat and the cloak or mantle typical of the Southern colonel of the old school—was impressive. Once seen, he was not easily forgotten. Though modest and unassuming in manner, few persons ever combined in one character more of the elements of success; in industry, perseverence and determination he resembled the great John Hunter.

HIS DRUG STORE AND HIS TWO FAVORITE PRESCRIPTIONS

It has been claimed that Toland's methods in his practice were not always ethical. Be that as it may, his reputation extended over all the central and northern coast, and when the miners and mountaineers came to San Francisco to seek advice, Toland was the man to whom they went, and he usually either cured them or greatly alleviated their symptoms. He had his own drug store and, it is

said, but two favorite prescriptions. One of these prescriptions consisted of various mixtures of iodid of potash, the other of mercury with nauseous drugs as adjuvants. Back of his office, in what he called his surgery, were two famous barrels, one labeled "anti-syph" and the other "anti-scrof." "He kept office hours in the morning for private patients; in the afternoon for clinic patients. No charge was made for the examination of these clinic patients nor for the prescriptions; but at the end of the corridor, next the stairs, was Doctor Toland's drug store, and none but his pharmacist could decipher the scrawls of the squeaking quill pen. Some idea of the volume of the business done by this drug store could be obtained from a glimpse at the row of scrapbooks on the top shelf which encircled the room—a veritable frieze of huge books of prescriptions."[12] Copies of the 581,000 prescriptions which he had given out in only fifteen years made twenty-three volumes. These he explained to his students in his lectures, and the ingredients were alleged to be a great boon to his patients. Prescriptions were renewed at $5 a bottle, but he never gave out their contents except as a contribution to his students. "This drug store was a real gold mine. It is interesting to note, too, that Doctor Toland did an enormous mail-order business. People in the mines of California and Nevada found it easier to write an account of their symptoms to Doctor Toland than to make the long journey by stage to see him. Medicine was forwarded by express, and Wells, Fargo & Company collected the fee."[12] One of his former students, who later became a great physician and a professor, said to me: "When my first medical work called me to Crescent City and it became known that Toland was my teacher, my reputation was made. Men flocked to me, and when it was known that I held the secret of 'anti-syph' and 'anti-scrof' they went no further. Well supplied with these mixtures, and carrying in my saddlebags a few simple remedies and an abundance of bread pills, I defied disease, for I soon found that good nursing with a few bitters, and my one specific, were sufficient to carry through all but mortal diseases."

A KEEN DIAGNOSTICIAN

Toland's method of diagnosis was impressive. He rarely asked a patient a question, nor did he allow any detailing of symptoms. Like Sherlock Holmes, he read the face and studied the physical aspects, and from these guessed the disease—not always difficult, considering the lives his patients had led. From his evident recognition and successful treatment of one of the most common, protean, and deadly diseases—syphilis—it is not surprising that he got results when others failed. Many years ago, as an interne, I heard one medical philosopher and great teacher talk to his students, and, in order to impress them, he intentionally exaggerated: "The diseases that the human flesh is heir to can be roughly, and for practical purposes, divided into two large groups—syphilitis and nonsyphilitic, the former comprising 95 per cent of the whole. If you can diagnose and treat syphilis in its various manifestations, you need have no doubt as to your success."

Until a few years ago syphilis was a taboo subject, to be mentioned only in a whisper behind closed doors. Now, almost sixty years after Toland's death, this ever prevalent scourge is at last being brought out from under cover and considered rationally. The people are being given public lectures by the medical profession, warning them that syphilis is a menace to our civilization. Indeed, one cannot but reflect that "knowledge comes, but wisdom lingers." This national campaign should have been started in Toland's day. There can be no doubt that it was just this idea, the education of the public and, thereby, the consequent preservation of the health of the community, that induced Levi Cooper Lane—a later confrère of Toland's and also a great medical leader in his day, to whom San Francisco medicine is much indebted—to inaugurate a series of medical lectures to the public. But, as nearly always, this innovation was frowned upon by his colleagues, and Lane was the brunt of their caustic remarks. Verily, if one would avoid the criticism of his day he must not be ahead of his time. Small minds cannot see the mountain near. However, one should take consolation in the thought that discussion of one's contemporaries is conversation, not criticism.

A DOMINANT PERSONALITY

He was master in the power of suggestion and in inspiring great confidence in his patients by his dominating personality, and he is said to have wrought marvelous cures in his day. It is little wonder that he soon had the largest practice on the Pacific Coast. This did not arise from a desire to outstrip his competitors, but because of the combination of native ability, splendid training, and a rare personality. He seemed to have a place that no one else could fill. Those who knew him best have written of his manifold generosities and of his lavish donations to charity, which often amounted to $100 a week.

384 Post Street.

(To Be Continued)

CLINICAL NOTES AND CASE REPORTS

EOSINOPHILIC BODIES IN MEASLES

By H. H. Parsons, M.D.*
Shreveport, Louisiana

IT is generally accepted that the virus of measles exists in the blood, nasal secretion, and the bronchial secretion.[1,2]

Several organisms have been described as having been found in the blood[3] and nasal secretion.[4] Both Gram-negative and Gram-positive cocci have been described, but none of them have been accepted as the etiological factor in measles.

Degkwitz[5] claims to have cultivated the virus.

* Member of the San Bernardino County Medical Society, California.

1 Anderson and Goldberger: (a) J. A. M. A., Vol. 23, No. 57, pp. 476, 971, 1911. (b) Am. J. Dis. Child., 4:20, 1912.
2 Blake and Trask: J. Exper. Med., 33:385, 1921.
3 Tunnicliff: J. Inf. Dis., 37:193, 1925.
4 Guardabassi: Pediatria, 1927.
5 Degkwitz: J. Inf. Dis., 41:304, 1927.

No reference having been found of anyone having made a daily examination of the blood of any virus disease from its inception to far into the convalescence, the author decided to carry out such examinations. On November 7, 1934, a pre-eruptive case of measles became available for study.[6] The eruption appeared on November 8, 1934.

Smears were taken daily from the blood and nasal secretion, and from the conjunctival sac, from November 7 to 17 inclusive, when the taking of smears was interrupted.

The smears were stained with a modified Fontana silver stain, and minute bodies were found in some of the red blood cells, free in the mucus of the nasal secretion and free in the smears from the conjunctival sac.

Since then eleven other cases of measles have been similarly examined, blood smears being taken from the day of the appearance of the rash up to and including the eighteenth day, and all have shown eosinophilic bodies in the red blood cells.

After trying many staining methods, it was found that these bodies are eosinophilic, that aldehyds intensify the staining, and that prolonged staining is necessary.

Wright's, Giemaa's, and other such stains have proved useless, as have basic stains.

STAINING METHOD

From the above data the following method of staining was evolved:

1. Make very thin smears. Dry in air.
2. Flood smear with absolute methyl alcohol and stand slide on end and allow to dry.
3. Place in Coplin jar containing a solution made as follows: water 90 cc., formalin 10 cc., and allow to remain for twelve hours.
4. Transfer slide, without washing, into another Coplin jar containing: eosin .3 gm., formalin 10 cc., water 100 cc. Stain for twelve hours.
5. Wash in running water, then blot or dry slide in the air.

All solutions should be filtered.

No counterstain is used for blood smears, but it is advisable to use a counterstain if mucus, pus, or other materials are to be examined. All smears are stained first as above; then, to counterstain, place the slide in another Coplin jar containing China blue .3 gm., formalin 10 cc., water 100 cc. Stain for from thirty seconds to thirty minutes (it will vary), or stain until the slide takes on a pale blue color. Do not stain deeply, as this will hide the eosinophilic bodies. Mucus, pus, etc., stain pale blue, the bodies an eosin color. Normal controls should be run on each slide or set of slides.

Normal blood contains some eosinophilic bodies in some of the red blood cells, but they are not numerous nor uniform. They are usually large and occur in the proportion of about one body to every eighty red cells. They may possibly be protected bodies.[7]

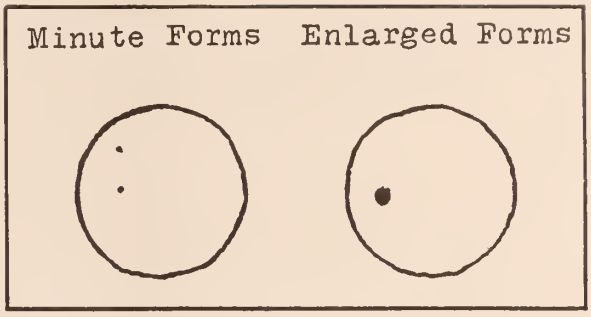


Fig. 1

BLOOD FINDINGS IN MEASLES

In measles blood the bodies are found in the red blood cells, rarely in a white cell or a platelet, or free in the plasma. They usually occupy the area between the periphery and the center of the red cell, and they generally occur in the proportion of one or two bodies to every sixth red cell. On the sixth to seventh day certain of these bodies seem to develop greatly in size, usually to about that of a coccus, and they make their maximum development from the ninth to the twelfth or fourteenth day. From the fourteenth to the seventeenth to eighteenth day they become pale, take the stain less readily, lose their outline, and by the eighteenth day have usually disappeared from the blood. They are eosinophilic, very refractile, both in the minute and larger forms, having a bright orange color. The red cells are stained a brilliant pink.

The color plate does not give an accurate conception of their appearance, as I have been unable to get the proper colors to show the refractility.

Both the minute and larger forms occur in the nasal mucus and in the smears from the lacrymal sac. However, it is not known how long they remain there.

Several cultural trials were made after the method of Goodpasture,[8] but the results were not conclusive.

There are certain points to be observed in examining these smears, chiefly to discard any slides that show large numbers of bubbles on the red cells, or slides that are not nearly perfect. Slides ground on one end on the flat are useless, as they are pitted all over from the abrasives used in grinding; these pits retain the stain and lead to endless confusion. Cells that are deformed, or that touch or overlap one another, should not be counted, as they often have bodies that lead to confusion. Unless one has had these bodies demonstrated to him, considerable difficulty will be experienced in identifying them.

Other eosinophilic bodies have been found in the blood of mumps, rubella, chicken-pox, poliomyelitis, arthritis, herpes influenza, the common cold—the descriptions of which I hope to publish.

I have termed these bodies "eosinia" for convenience.

These bodies were described and demonstrated before the Calhoun County Medical Society (Alabama) on November 5, 1935.

247 Jordan Street.

6 John Hogue

7 Raus, P., and Jones F. S.: Jr. Exp. Med., 23:601-612, 1916.

8 Goodpasture, E. W., and Buddingh: Amer. Jour. Hygiene, Vol. 21, No. 2, 319-360, 1935.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

WHAT IS TO BE EXPECTED OF BLOOD TRANSFUSIONS

I. INDICATIONS FOR BLOOD TRANSFUSIONS IN SURGICAL PATIENTS

LeRoy Brooks, M.D. (2000 Van Ness Avenue, San Francisco).—In the not too distant past, blood transfusions were used only in extreme emergencies. This idea still persists in the minds of many patients and their families. Too often, when a blood transfusion is mentioned, the impression is created that death is lurking around the corner. Indications for transfusions in surgical patients today are quite sharply defined, often prophylactic in nature, and may be grouped as follows:

1. Shock due to hemorrhage, accidental or operative trauma, or toxemia.
2. Acute infections.
3. Chronic infections.
4. Poor surgical risks.
5. Blood dyscrasias requiring surgery.

We now know, in shock, that a physiological state exists in which there is an insufficient amount of blood in circulation. The plasma migrates through the capillaries into the body tissues. In severe shock, if the volume of circulating fluid is furnished by saline, glucose or other crystaloid solution, this thin liquid rapidly passes through the capillaries, and will not sustain a satisfactory volume of circulating fluid. A colloidal type of solution must be used with molecules sufficiently large to prevent it from passing through the injured capillaries too readily. Gum acacia solution with glucose is preferable to the crystaloid solutions, but large volumes of whole blood must be given first place.

Transfusions offer the most dramatic results in patients in shock from the simple loss of blood without extensive tissue injury. Such incidences are not infrequent in maternity cases or in accidental hemorrhage from operations, when the source of the hemorrhage has been stopped. Patients unconscious from such hemorrhage, if blood is given immediately, will often regain consciousness during the transfusion. From 500 to 1,000 cubic centimeters quantities are usually needed and may have to be repeated.

In shocked patients from accidental or operative trauma, the response to transfusions is not always so satisfactory as in the cases of simple hemorrhage. This is due to the fact that the cause of the shock, tissue injury, is continuing to act. However, large transfusions repeated offers the best chance for recovery and, if given early, will prove successful in many cases which would otherwise terminate in a fatality.

Of great interest is the type of case in which there is a massive concealed hemorrhage—that is, a hemorrhage that cannot be definitely located so as to mechanically control the bleeding. Gastro-intestinal hemorrhages or lung hemorrhages offer good examples of this type. We have had many discussions with internists who, in such cases, feared the giving of blood on the basis that the increased volume would cause an aggravation of the hemorrhage. We agree fully that the circulating volume of fluid should not be increased by giving solutions such as glucose. Our experience, however, forces us to the conclusion that when a patient is approaching the state of shock from a concealed hemorrhage, the whole blood transfusion will replenish the volume of fluid and tend to stop the hemorrhage. The explanation which we offer for this is the increase in the coagulation of the blood following the transfusion. Whether this explanation is correct or not, clinically, transfusions do not cause an increase in the bleeding in such cases. In such cases, donors should be kept in readiness, and if the blood pressure falls below 80, a transfusion should be given immediately. A second donor should be kept in readiness, and even a third to keep the patient's blood pressure above 80, preferably above 100, and ward off destruction of the vital centers. We have given, with success, as many as six blood transfusions within one twenty-four hours, infusing altogether more than 3,000 cubic centimeters of blood. Care must be exercised that all donors and the patient are of the same type when such large quantities of blood are given. At times, in these desperate cases radical measures must be resorted to, and the element of time is extremely important.

If the patient is in shock from the absorption of toxins from an overwhelming infection, blood transfusions are of practically no value. It is encouraging to note that transfusions as a last resort, just to satisfy the family and friends when there is no chance of their having any beneficial effect, are not so often resorted to in these modern times as previously. The results of this type of practice accomplish nothing of good, and only serve to discredit one of our most effective methods of treatment.

Some of the severe surgical infections with or without definite localization, with high temperatures, evidence of lack of normal resistance against the given infection, even in the absence of anemia, blood transfusions in small doses, 200 to 300 cubic centimeters given daily or every second day, are of unquestionable value. We are definitely of the opinion that it is far more valuable than the use of the so-called antistreptococcic serum, "prontosils," magnesium sulphate, hydrochloric acid, and myriads of other solutions that are used on an empirical basis. A good example of this type of septicemia is seen particularly in children, from ear or mastoid

or lateral sinus infections. A blood transfusion increases the patient's resistance, furnishes needed food and, no doubt in many instances, makes it possible for the patient to localize or overcome the generalized infection.

Patients suffering from subacute or chronic suppurative processes present a group of people to whom transfusions offer much. Along with other supportive treatment, repeated small blood transfusions should be used once or twice a week to keep the hemoglobin above a minimum of sixty. It is not uncommon to see patients with prolonged suppurative processes, such as in bronchopneumonia, empyema, lung abscess, subdiaphragmatic abscess, liver abscess, protracted peritonitis, osteomyelitis and other types of prolonged surgical infections, develop a marked secondary anemia. Such patients, if transfused, will often recover; but if not transfused, not infrequently will not recover.

The bone marrow and blood-forming tissues must be adequately nourished and oxygenated, in order to meet the added call due to the additional destruction of the blood by the infection. Besides making recovery more certain, if the hemoglobin is kept up, these patients will develop fewer complications, have a shorter convalescence, and recover with greater certainty and less morbidity. It is our experience in chronic infections that repeated small blood transfusions, from 200 to 300 cubic centimeters, are preferable to the larger transfusions of 500 cubic centimeters or more. However, if the patient is anemic, with a hemoglobin below forty when first seen, at the first or even the second transfusion, a full 500 cubic centimeters may be preferable, and subsequent blood be given in small quantities. It is remarkable indeed to see pale, unhealthy, indolent type of surgical wounds, which are healing slowly with an excessive amount of production of scar tissue, change their color and develop normal, healthy-appearing granulation tissue, and the healing process proceed with greater rapidity. It is probably in this group of patients that blood transfusions, when judiciously used, are most useful. It is our experience that this group of patients now receives blood transfusions more often than in the past. However, truth forces the statement that in some quarters, as yet, there is considerable lethargy in giving transfusions as often as they are indicated.

A fourth group of patients to whom blood transfusions are of great value are the poor surgical risks. One doing any volume of general surgery quite infrequently encounters a patient who must be operated upon and is not a good risk. Time and space do not present an opportunity for full discussion of the broad use that can be made of blood transfusions in this group. Good examples are bowel resection, gastric resection, thoracoplasty, lung surgery, pyloric stenosis in starved infants, and numerous other necessary major surgical procedures that must be carried out, particularly in children and people past the middle age of life.

Here again it can be said without fear of contradiction that, in general, transfusions in these cases are not used as often as the good results obtained by the giving of blood warrants. There is no other single procedure which can be compared with the use of transfusions in the preoperative preparation and the postoperative convalescence in the poor surgical risk. A good working rule to adopt is, that when the surgeon begins to consider giving the patient a transfusion, that is the time to give the blood.

The fifth or final group of surgical patients requiring transfusions are those unfortunates suffering from blood dyscracias with a tendency to bleed. It is, fortunately, true that there are not many such cases. Occasionally, one is forced to operate upon such people, and the question of hemorrhage is a major one. For example, we might mention thrombocytopenic purpura and other less well-classified hemorrhagic dyscracias requiring surgery. It is even possible to do surgery on a hemophiliac, if the patient is given adequate transfusions.

The reader no doubt is struck by the enthusiasm expressed for transfusions. For this enthusiasm to be justified every care must be exercised in the selection of donors. Both grouping- and cross-agglutination tests must be a routine, and the possibility of transmitting syphilis and malaria must be conscientiously guarded against. We prefer whole blood when given with dispatch, but a citrate transfusion well done is preferable to a whole-blood transfusion poorly done.

* * *

II. INDICATIONS AND CONTRAINDICATIONS FOR THE USE OF TRANSFUSIONS IN CHILDHOOD DISEASES

Howard R. Cooder, M. D. (3875 Wilshire Boulevard, Los Angeles). — The following statements are an attempt to present the evidence for and against the transfusion of blood in the diseases of children. The experiences upon which these statements are based have been gathered almost entirely at the Los Angeles Children's Hospital. About two years ago, when transfusions were at their height of popularity in this hospital, a reaction of inquiry into the value of this therapy began. The results given here are the deductions and the beliefs of this writer, and not necessarily an agreement among all the physicians upon the staff of this hospital. Such beliefs have been derived partly by the statistical method, when it could be used, and in part have been built up as clinical impressions.

More than one thousand transfusions are covered by these observations. The method of transfusion used has been the direct syringe technique, and in no case has a citrated transfusion been given. This is an important difference because the citrate method is slower and does not produce the sudden load which is added to the blood stream when the direct syringe method is used. On the other hand, citrate reactions have been avoided.

CONDITIONS IN WHICH TRANSFUSION IS OF CERTAIN BENEFIT:

1. *Acute Loss of Blood, Such as Accidental Hemorrhage.*—Transfusion is necessary only when enough blood has been lost to cause physical embarrassment. Transfusion is not necessary for small

hemorrhages, because such small blood losses will be quickly made up by the blood-forming organs without assistance. The loss of fluid can be replaced by subcutaneous or intravenous saline administration.

2. *Severe Anemia.*—By this is meant a dangerous situation in which the hemoglobin has dropped to 30 or 20, or lower, and the blood cells have dropped to a like degree. Such an anemia might improve by other methods if given enough time; but the patient's general condition may be so threatening that he needs the quick assistance of a transfusion in order to add at least 10 to 20 per cent to his normal blood count and hemoglobin.

3. *Septicemia, With or Without Anemia.*—If one can be sure that the blood of the donor contains antibodies which are specific for the disease, and that there is a sufficient amount or titer of these antibodies in the blood of the donor to be really helpful, then a transfusion for this purpose is definitely indicated. If the patient's blood culture shows that he is suffering from septicemia due to certain streptococci—for instance, as a complication of scarlet fever or of otitis media—then the patient would better be given a transfusion of immune serum rather than the blood of a casual donor. It is possible to obtain from certain serum centers a well-prepared and well-tested serum whose antibody strength against the bacteria involved is known. The whole question of transfusion for septicemia is in dispute; it is usually a measure of last resort. The only way that its value can be stated is to know the antibody properties of the blood which is available from donors.

4. *Purpura, Primary or Secondary.*—Transfusion may be given when the patient's platelets are low and there is serious hemorrhage. By adding normal platelets, the hemorrhage will be stopped at least for a time. Repeated transfusions should not be given, because they will depress the platelet output of the hematopoietic system. Transfusion should be given only if the cellular elements are low. It is usually indicated in symptomatic purpura rather than in the essential type.

5. *Hemophilia.*—In this condition transfusion is clearly indicated, and may have to be frequently repeated as a life-saving measure. Transfusion furnishes normal platelets, which are able to break down quickly and assist in the formation of the clot required to stop bleeding. These normal platelets, of course, soon disappear, and transfusion will have to be repeated if the patient has another attack of bleeding which cannot be stopped by other methods.

6. *Leukemia.*—This is always a fatal disease in children. The patient may be kept alive for a certain time by transfusions which no other form of treatment will afford. Transfusions are given, time after time, when the patient's blood reaches a sufficiently low level in order to keep him alive for the sake of the family. More transfusions are given in this disease than in any other. The patient will sooner or later die, although the end may be deferred for months. In the case of a child, it is doubtful whether, for any other reasons than sentimental ones, it is worth while to prolong the patient's precarious and unsatisfactory life in this manner.

7. *Shock.*—In this condition, where a part of the blood of the body stagnates in a certain so-called "pool," fluid must be added to the blood volume of a kind that will remain in the vessels and restore the blood pressure. The transfusion of blood fulfills these needs and is of decided benefit.

CONDITIONS IN WHICH TRANSFUSION IS OF DOUBTFUL VALUE:

1. *Pneumonia.*—Transfusion is very much used in severe cases of pneumonia. The thought back of this usage is that normal blood or serum will furnish some kind of stimulus or antitoxic property to overcome the toxemia. In the observation of this writer, transfusion for the toxic type of pneumonia has seldom or never been of any help to a patient, and has sometimes done harm. If the blood shows severe anemia and depletion, transfusion may be called for just as it would be in any other severe blood loss. In severe toxemia with cyanosis and involvement of the nervous system, transfusion does no good. In collapse of the vasomotor system, transfusion is probably wrong, because the capillaries are engorged with blood due to reasons which have nothing to do with the blood itself, so that to add other blood at this time may only increase the undesirable condition. If the patient's poor condition is due to a failing heart, then it does not seem rational to put an additional amount of blood into the vessels, because we are not at all sure that the heart muscle will be stimulated by anything in this new blood, and to increase the blood volume will probably further embarrass the heart. If the heart is overworking and the pulse bounding, this is probably the time for venesection and the additional load of new blood is distinctly contra-indicated. Infants who are very ill with pneumonia frequently need intravenous saline solution to repair their dehydration, rather than the scanty fluid content of a small transfusion. Statistics, which deal with the value of any kind of treatment in relation to pneumonia, must be carefully gathered and interpreted. So far as observations in this hospital are concerned, transfusion for pneumonia in children has seemed to be associated with a higher death rate.

2. *Enterocolitis.*—This is a common and a serious condition in very young children, both in hospitals and in private practice. The patients lose more fluid than can be put into them, and rapidly become very ill and subject to complications. The death rate is high, and a large percentage die with pneumonia as a terminal complication. Consequently, enterocolitis and pneumonia have to be considered together, as it is often impossible to say which is the greater illness. The first and greatest requirement here is fluid replacement, and the most valuable recent addition to our methods of treatment is the intravenous drip of normal saline. Transfusion has been much used during the height of this disease and as a measure of last resort. The chief thought lying behind this therapy is that the fresh serum contains some restorative quality. It is the

opinion of this writer and of others on the staff of this hospital that transfusion has not helped in the mass of cases with enterocolitis. If severe anemia has been produced by the toxemia, a small blood transfusion may be given, but even then a transfusion of serum may be better. Blood cultures should frequently be made, and if positive for certain kinds of streptococci, serum which contains antibodies for these organisms may be given. Its use has apparently saved some lives.

3. *Postinfection, Depletion and Prostration.*—Transfusion is frequently used in the state of depression which follows a severe infection. The reasons given by those who employ it are not always clear. It is frequently referred to as a "boost." If the patient is severely anemic, a transfusion may be allowed; but it seems to be of value only to the exact extent of the amount of blood which is added, never more than 10 or 20 per cent of the patient's total blood volume. Many patients who have been severely ill will be depressed in various ways for weeks and months; children frequently show a persistent fatigue. It appears that what these patients need is chiefly rest, no matter how long it takes, and food, and an improvement in their mental and physical hygiene plus an iron tonic. Antibodies and the other restorative factors of fresh serum, which a transfusion is supposed to furnish in this condition, are extremely doubtful unless the donor's blood is tested. It is better to use a known immune serum. In certain convalescent conditions the patient's blood shows an increased tendency to clot, and to add new blood at this time will create a hazard of thrombosis. Patients have sometimes died during or soon after transfusions for reasons that are unexplainable, and seem to have something to do with a sudden coagulation and obstruction of capillaries.

4. *Leukopenia.*—This condition is found in children as a result of the use of arsenic preparation and a few other drugs, but most commonly as the result of chronic or acute infections. It is not very uncommon and it may become more common. These patients are very ill, and transfusions are given as emergency treatment. The question is always asked, is the patient ill because of a low white count or is the white count low because of the main illness? Transfusions depress the blood-forming system for a time and decrease the white count as a rule, although they may occasionally increase it. The reticulocytes are decreased. It is a common observation that blood counts done every day after a transfusion will show that the blood elements stand still. In leukemia a transfusion causes the white count to drop. If these things are so, then it is not rational to give a transfusion for leukopenia, because the white count is apt to drop still lower. In spite of the above contraindications, the patient may have to be transfused if necrosis of throat tissues threatens to occur.

5. *Surgical — Preoperative and Postoperative States.*—Transfusion is very popular with some surgeons, and is given as a routine measure by them. The reasons advanced are often not satisfactory, and are not founded on any known requirement, but seem to depend upon the empirical beliefs of these surgeons. The need of such transfusions is doubtful, and their value is impossible to measure. One nose and throat surgeon may give a transfusion before all of his mastoid operations, while another surgeon may never use it and the ultimate results in the two groups of patients will be the same. One example of irrational procedure may be cited—that of giving a transfusion before or after a brain operation. In this condition, with the many delicate ligatures of brain vessels and the danger of hemorrhage, it is not desirable to raise the blood pressure, and yet this is just what such a transfusion will do.

6. *Epidemic Disease Prevention.*—Whole-blood transfusion and serum by intramuscular injection are used to fortify the body against several specific ailments either before or after onset. An outstanding example is poliomyelitis. So far it has not been possible to show statistically that poliomyelitis immune serum has mitigated an epidemic or has prevented cases. The titer of immune bodies in any donor or in any pool of serum may be high; it may be low; it can be known only by determining its protective value for monkeys.

CONDITIONS IN WHICH TRANSFUSION IS CONTRAINDICATED:

1. *Uncomplicated Anemias Due to Lack of Iron.* This is a very common condition at all ages and particularly in infancy. Patients with a hemoglobin of 50 or 40 per cent, or even lower, do not need to be transfused. The administration of sufficient quantities of inorganic iron compounds by mouth for a moderate length of time will restore the hemoglobin of these patients to a normal condition. Of course, the main cause of the defect will have to be corrected.

2. *Pneumonia With Embarrassed Circulation.*—This has already been mentioned, and the reason stated why it is wrong to force more blood into an already overworking heart. The withdrawal of blood—that is, venesection—is probably better.

3. *Nephritis.*—Most patients with chronic nephritis look anemic, but are only moderately so. Patients with nephrosis have a surprisingly good blood count. Their white appearance is due to edema of the skin or perhaps to a capillary constriction. Plasma proteins are, of course, frequently abnormally low, and a transfusion of normal plasma has been used to combat edema, but without much success. The transfusion of whole blood does not help the condition of nephritis at all; in fact, it probably increases the load on the damaged kidneys to excrete the new substances which have been added. Transfusions in cases of nephritis sometimes have been followed by anuria.

4. *Recovery Stage of Infection.*—It has already been stated that here there are increased protein and platelets in the blood with increased tendency to coagulation, and that the addition of transfused blood at this time is somewhat dangerous. Sudden deaths have occurred for reasons difficult to explain. Transfusion is at least not necessary.

5. *Allergy.*—When transfusing a patient who is highly sensitive to certain proteins, it must be care-

fully ascertained that the blood of the donor does not offend by containing these proteins, which it may do at all times, and particularly after the donor has just eaten.

6. *Acidosis.*—A patient in this condition has abnormal substances in the blood which are excreted as organic acids. These substances are known to cause increased precipitation of hemoglobin; and, therefore, such a patient should have the acidosis corrected before transfusion of blood is given. Particularly should fluid be given to such a patient, and the acidosis and anhydremia corrected before the patient's blood is matched against donors, as the results may be different under these altered conditions.

* * *

III. METHODS OF TRANSFUSION

Clifford Sweet, M.D. (2940 Summit Avenue, Oakland).—Two methods of blood transfusion are in general use in the care of infants and children, namely, the transference of whole blood from the donor to recipient by the Lindemann multiple syringe method, and the indirect method by which the donor's blood is collected and mixed with sodium citrate solution, and then given after varying intervals of time to the patient by gravity or syringe, intravenously, intra-abdominally, or even subcutaneously.

The advantages of the multiple syringe method are not great, since there is no proof that the immediate transfer of undiluted blood from donor to patient is of any greater benefit than a corresponding amount of blood which has been citrated. On the other hand, the technical difficulties of this method are numerous when compared with the indirect, citrate method: (1) The multiple syringe method requires two skilled operators who can work together as a team, a nurse who can pass the syringes to both operators in a satisfactory manner, and a second nurse or orderly who can hold the patient if he is refractory, while a third unscrubbed nurse should also be present in case of need. When the citrate method is used, the blood can easily be collected by one operator with the assistance of one nurse, and can usually be given to the patient later by the same two persons. (2) In order to avoid any possibility of transferring infection from the patient to the donor, enough syringes must be provided so that each syringe is used only once; while if citrated blood is injected by the syringe method, only two syringes are needed—one to be filled by the nurse, while the other is being emptied into the patient's vein. (3) A much greater degree of skill is required to keep a needle in the lumen of a vein, while numerous syringes are being attached and disconnected, than when the needle is merely held in place while blood is flowing from the donor into a partial vacuum flask containing citrate, or when it is flowing into the vein of a patient (especially a small child) by gravity. (4) A transfusion of undiluted blood must be done quickly in order to avoid clotting, and in certain instances it may be undesirable, if not dangerous, to suddenly increase the volume of the circulating blood in a very young, acutely ill, or feeble patient, such as a child with pneumonia, a feeble or premature infant, or a child with a congenital heart disease, while a citrated blood transfusion can be given as slowly as need may dictate, even by the continuous intravenous drip method. Also the danger from reaction is reduced when the blood is introduced more slowly. (5) While it is possible to set up for a transfusion of undiluted blood in the patient's room when he cannot be taken to the operating room, it is much simpler to take citrated blood to the patient and give it as one would any other fluid by vein. (6) Citrated blood can be taken from the donor in sufficient amount at one time for two or more transfusions on successive days, provided it is kept in storage at low temperature.

Despite all the advantages of the citrate method, the writer prefers to use the multiple-syringe method of giving undiluted blood whenever possible.

However skillful the operator may be, he may fail if he does not give careful attention to the needles he uses. If the needle has a long, spear-type point, the danger of piercing the posterior wall of the vein is greatly increased. The bevel of the point should not exceed 60 degrees, and the needle should be sharpened to a razor-edge on a fine stone. The point should not only be sharp with cutting edges, but narrow enough to pick up and transfix the outer wall of the child's small, movable vein; the lumen of the needle should be as smooth as possible, and to insure this it should be thoroughly polished with fine dampened emery, or other abrasive material, carried upon the largest possible adapter. A short needle is much better than a long one since it is easier to aim accurately at short range than at long. Introducing the needle until the hilt is pushed firmly against the overlying skin assists greatly in keeping the needle in place. Since I learned several years ago, from Dr. A. H. Ziler of Los Angeles, to thus "lock" the needle in place, I have had very little difficulty in staying in the lumen of even very small veins. A Fordyce wing, which is readily attached to any needle after the manner of an adapter, gives one a firm handle for holding the needle in place, and I prefer to introduce the needle into the vein with only the wing attached, rather than to do so with the needle mounted on a syringe.

The skin is anesthetized with one per cent procain at the chosen site, the needle is introduced through the skin at an acute angle, and the vein is then fished for until the point engages the outer wall sufficiently for the vein to follow trial movements of the needle, after which the base of the needle is depressed until it is nearly parallel with the skin, and then moved forward in the lumen of the vein until the hilt brings the skin taut in the line of entrance. During the forward movement of the needle, the wing is held as one holds a pen or a scalpel, since any rigidity in the operator's hand greatly increases the probability of going through the vein rather than along the lumen.

If syringes are used, they should be held with the hand relaxed until connected to the needle, and then the connection made firm by clockwise rotation of the syringe. Detachment should be accomplished

by short counter clockwise rotations of the syringe, thus avoiding pushing or pulling on the needle.

The sites for transfusing infants and children are several, namely, the scalp veins, the jugular, the anterior cubital at the elbow, the internal saphenous, just anterior to the internal malleolus of the tibia, and the superior longitudinal sinus. The last-mentioned should not be used, but if one has the temerity to choose this route, he should use the citrate method and introduce the blood only under the lowest possible pressure of gravity.

The scalp veins in infants can often be used for the introduction of citrated blood under syringe pressure. The jugular vein is often the easiest one to use in infants, and even older children, provided the head is held firmly, fully extended over a sand bag or the end of the table, and at the same time strongly rotated laterally in order to prevent the jaw acting as an obstruction to a direct line of approach; and, most important of all, that the needle be introduced along the lumen of the vein for a great enough distance, preferably about an inch, so that the movements produced by the child's breathing and crying will not lift the vein off the needle.

The internal saphenous at the ankle must be exposed by cutting down upon it under local anesthesia in very young infants, nicking it with a knife-point or a small, sharp-pointed pair of scissors, and introducing a blunt needle or a fine canula into it, through which citrated blood can be readily given. This is the best site and method for transfusing new-born infants, and if faced with the necessity of cutting down on the vein of an older child, scarring at this point is least objectionable. A considerable number of older children who have very small arm veins, or whose arm veins are obscured by subcutaneous fat, present an ankle vein which can be readily entered by a needle puncture—provided the needle is very sharp. A few infants and most older children have arm veins which can readily be used for transfusion.

The proper use of a local anesthetic is important in order to reduce the struggles of the child and to prevent the operator from hurrying to get the needle well placed in the lumen of the vein. Haste at this point usually means failure. Also the child's arm *must not move* during the transfusion. I suppose the arm could be fastened to a splint, although I have not used this method. The child should be completely restrained, by firm wrapping in a blanket, leaving only his head and the arm to be used exposed. A small sand bag or folded towel should be placed under the child's elbow, in order to extend the arm fully. A nurse should then be seated on a stool beside the head of the table, and instructed (the best method of instruction is demonstration by the operator) to grasp the child's shoulder firmly in her hand with the fingers spread fanwise over the patient's scapula, and the thumb placed *emphatic,* exactly over the acromian process. With this hand the patient's shoulder is held firmly against the table; with the other hand she takes a firm grip on the patient's free hand from beneath with her thumb across his palm and the patient's thumb under her palm. She must not only fully extend the patient's elbow and prevent any flexion, but she must also prevent any rotation of the forearm. If the particulars of the above-described hand grip are not fully observed, rotation of the forearm, with dislodgement of the needle from the lumen of the vein, will almost certainly result. Proper placing of the nurse in a comfortable posture, with the elbow of her hand holding the arm well flexed and resting on her knee, or on a table or stool, will enable her to hold the child's arm motionless for a sufficient time, while she will be entirely out of the way of the operator, who is seated on the opposite side of the child's arm. I am indebted to Dr. Q. O. Gilbert of Oakland for this most excellent way of holding the patient's arm.

One other small detail of technique, attention to which raises the percentage of successful transfusion greatly, is the placing of the tourniquet just tight enough to fully distend the vein to be used, but without interfering with the continuance of circulation. Even though several readjustments must be made, time is eventually saved and failure will less often result.

Use of Benzedrine Sulfate in Seasickness.—Hill examined one hundred cases of seasickness. Except as conditions of hypertension, cardiac disease and unusual degrees of excitability contraindicate the use of benzedrine sulfate, these cases were taken consecutively as they presented themselves. The group comprised eighty-two women and eighteen men. Their average ages were 36.6 and 33.2, respectively. Satisfactory results were obtained in thirty-nine cases, in all of which the improvement was unequivocal, every likely fallacy having been carefully excluded. Those responding to benzedrine alone showed a mean pulse rate of 69 recumbent, increasing by 18 per cent on sitting up; in the group of failures the corresponding figures were 77 and 11 per cent; that is to say, a tendency to vagotonia predominated in the first group. It is doubtless in the vagotonic variety of seasickness that benzedrine finds its greatest usefulness. In its mode of onset this sickness reproduces in slow motion the prologue to an attack of syncope. The clinical signs point to a disturbance of the stabilizing control of the circulation whereby the effects of low arterial pressure are neutralized by tachycardia, and vice versa. Doubtful cases numbered forty. This group comprised not only those of whom it was doubtful whether they had improved, but also those concerning whom there was any room for doubt as to how improvement had been brought about. Psychologic factors were reckoned with. Analysis of the twenty-one cases which failed to respond to benzedrin shows that most cases of seasickness are amphotonic. In some cases of extreme vagotonia the dosage (usually from 10 to 20 milligrams) was apparently not adequate; insufficient attention was paid to the influence of constipation. A study of the data provided here described yields two generalizations regarding the action of benzedrin. (1) When euphoria has resulted, the subsequent depression is insignificant in degree and duration compared with the preceding exaltation; probably the reaction coincides with the period of sleep. (2) The effects appear rapidly but are long-continued, as if a succession of interdependent physiologic changes had been initiated by the action of the drug. The rapid effect on gastric spasm, suggesting a local action, is obviously of great value in seasickness. It is remarkable how seldom benzedrin is vomited, even by patients who have openly despaired of being able to retain it. Enthusiasm for a new drug must be tempered with sound skepticism and the results scrutinized with care. For the suppression of sympathetic activity, especially that associated with dread of seasickness, bromids rank high. Benzedrin sulfate has great possibilities of usefulness in certain cases of seasickness in which there are signs of excessive vagus activity.—*British Medical Journal.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

HOWARD MORROW.....President
WILLIAM W. ROBLEE.....President-Elect
LOWELL S. GOIN.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

OFFICIAL BUSINESS

1. *Council Minutes, Two Hundred and Sixtieth Meeting, February 26, 1938.*

COUNCIL MINUTES

Minutes of the Two Hundred and Sixtieth Meeting of the Council of the California Medical Association*

Held in Room 302, Sir Francis Drake Hotel, San Francisco, Saturday, February 26, 1938, at 9:30 a. m.

1. **Call to Order.**—The meeting was called to order by the Chairman, Morton R. Gibbons, with the following members present: President Howard Morrow, President-elect William W. Roblee, Past President Edward M. Pallette, Speaker Lowell S. Goin, Chairman of the Council Morton R. Gibbons, Chairman of the Auditing Committee Karl L. Schaupp; Councilors Calvert L. Emmons, Carl R. Howson, Louis A. Packard, Axcel E. Anderson, Alfred L. Phillips, O. D. Hamlin, F. N. Scatena, T. H. Kelly, H. Rogers, Harry H. Wilson, J. B. Harris; Chairman of Public Relations Committee Charles A. Dukes, Secretary F. C. Warnshuis, Editor George H. Kress, General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

Absent: Doctors Tanner and Kiger.

2. **County Hospitals.**—Louis A. Packard, Chairman of the Special Committee of the Council on County Hospitals, presented a report for the committee and submitted points agreed upon and those to be considered. Members of the Council then reported on conditions in the various counties throughout the State. The value of institutions commissions was discussed in detail. It was suggested that the situation be discussed with interested civic organizations.

On motion of Edward M. Pallette, seconded by Lowell S. Goin, the question of securing an institutions commission was submitted to an informal vote.

The Council members were unanimous in their disapproving the undertaking at this time of the enactment to provide an institutions commission.

On motion of Louis A. Packard, seconded by Axcel A. Anderson, the informal vote disapproving the sponsoring of an initiative for a state institutions commission was declared to be the formal vote of the Council.

Further discussion of the county hospital problem was deferred until the afternoon session of the Council, at which time a supplementary report was to be submitted by the Special Committee.

3. **Annual Session.**—Attendance at the annual session at Pasadena was discussed and it was decided to order 1,750 programs and badges for that meeting.

4. **Medical Survey by American Medical Association.** The Secretary read a letter from the American Medical Association outlining its plan for making a survey of the medical needs of each county through the coöperation of county and state medical organizations.

It was moved by Charles A. Dukes, seconded by Calvert Emmons, that the Secretary be instructed to coöperate with the American Medical Association in the consummation of its program. Carried.

5. **Contribution for Entertainment for American Medical Association.**—The Secretary reported that the mail vote of the Council approved the contribution of $1,000 from the Association's funds for the entertainment of the American Medical Association during its meeting in San Francisco.

It was moved by Harry H. Wilson, seconded by A. E. Anderson, that the mail vote be approved and made the official vote of the Council. Carried.

6. **County Society Affiliation.**—Discussion was had of affiliation of physicians residing in counties where no county societies existed on account of the small number of physicians located in such counties.

It was moved by Edward M. Pallette, seconded by Louis A. Packard, that a committee of two be appointed by the Chairman to work up recommendations governing the affiliation of physicians residing in sparsely settled districts where no county societies exist. Carried.

7. **Committee on Public Relations Report.**—The Committee on Public Relations reported that it had arranged a conference on February 27 with representatives of Oregon and Washington state medical associations.

8. **Projectors.**—Bids on projection lanterns for use at annual sessions were presented.

It was moved by Junius B. Harris, seconded by Edward Pallette, that the Secretary be empowered to arrange for reconditioning of the projection lanterns and to purchase aluminum screens. Carried.

9. **Membership Certificates.**—Letter from the Secretary of the Alameda County Medical Association regarding membership certificates and pocket membership cards was presented for the information of the Council. The communication was ordered filed.

10. **State Institutions.**—Correspondence regarding the complaint of a member relating to one of the state institutions was presented.

The Secretary was instructed to advise the member that such complaints should be filed with the Director of Institutions, State of California.

11. **Medical Economics Committee.**—Resignation of Percy T. Magan of the Committee on Medical Economics was presented and, on motion of Charles A. Dukes, seconded by Howard Morrow, the resignation was accepted with regret and deep appreciation of the work done on this committee. Carried.

It was moved by Howard Morrow, seconded by Junius Harris, that Edward M. Pallette be appointed member of the Committee on Medical Economics for the unexpired term of Doctor Magan, term expiring 1940. Carried.

12. **Luncheon.**—At this point adjournment was taken for luncheon.

13. **Call to Order.**—The meeting was called to order by the Chairman.

14. **Farm Security Administration.**—President Morrow presented a letter from the U. S. Department of Agriculture Farm Security Administration asking the cooperation of the county and state medical associations in furnishing medical and hospital care to migratory agricultural workers.

It was moved by Karl Schaupp, seconded by Charles A. Dukes, that the Council give its approval to the plan in principle and that the President of the California Medical Association appoint a committee to work out the details consistent with the general principles and policies of the California Medical Association. Carried.

15. **Exhibitors at Annual Session.**—The Secretary was instructed to inform all exhibitors at our annual session at

* The minutes of the two hundred and fifty-ninth meeting of the Council of the California Medical Association were printed in the February, 1938, issue of CALIFORNIA AND WESTERN MEDICINE, page 125. Minutes in this series now printed are for the two hundred and sixtieth meeting.

Pasadena that we do not carry insurance on their exhibits covering loss by fire, theft or damage, and that they should carry such insurance.

16. **Mailing of "Journal."**—Discussion was had of the manner of mailing CALIFORNIA AND WESTERN MEDICINE. The Council felt that the present manner of mailing was satisfactory and the additional cost of mailing flat in envelopes was not justified.

17. **Hearing of Ross Carter and Roy Stevenson.**—The hour of 2 p. m. having arrived, the Council proceeded to hear the appeals of Ross Carter and H. Roy Stevenson of San Diego from the disciplinary action of the San Diego County Medical Society. The hearing was adjourned to a future date to be fixed by the Chairman.

18. **Proposed Amendment to Disciplinary Code.**—Lowell S. Goin submitted a report on proposed amendments to the By-Laws governing disciplinary procedures.

It was moved by Lowell S. Goin, seconded by Howard Morrow, that the Council recommend to the House of Delegates that Section 3, Chapter II, paragraph 7, be amended to correct a grammatical error by striking out the words "may be" in line 17 following the words "the answer or answers." Carried.

Doctor Goin then read the remainder of the report for the information of the Council.

It was moved by T. Henshaw Kelly, seconded by J. B. Harris, that copies of the report be submitted to each member of the Council for study and action at the first meeting of the Council at Pasadena. Carried.

18a. **Membership.**—It was moved by Lowell S. Goin, seconded by Howard Morrow, that the report of the Special Committee on retired and honorary membership be approved. Carried.

19. **Criminal Insane.**—It was moved by George H. Kress, seconded by J. B. Harris, that 1,000 reprints of the article on "Criminal Insane," by Ruggles Cushman, be made for future use. Carried.

20. **Resolutions.**—The Secretary of the Association was instructed to call the attention of component county societies to the inadvisability of having the language of resolutions so worded that members construe such resolutions to be by-laws.

21. **Legal Department.**—The General Counsel reported on the case of *Graun* vs. *Harder;* the Pacific Health Corporation and the Tator case.

The General Counsel, in accordance with previous action of the House of Delegates, was instructed to submit a report on malpractice at the annual session.

It was moved by Lowell S. Goin, seconded by Karl L. Schaupp, that the General Counsel assist in the Pacific Health Corporation case. Carried.

22. **Golden Gate Exposition.**—President Morrow presented a letter from the Executive Officer of the Golden Gate International Exposition and stated that $200,000 would be devoted to the health and science exhibit.

After discussion, on motion of Edward Pallette, seconded by Howard Morrow, Dr. Karl F. Myers was elected a member of the Association's Advisory Committee to the Golden Gate Exposition. Carried.

It was moved by Harry Wilson, seconded by T. Henshaw Kelly, that Doctor Kelly notify the Director of the Exposition that our Association's Committee which was appointed in response to their request, of which Doctors T. Henshaw Kelly, Edward Pallette, F. C. Warnshuis, and Hartley Peart are members, now includes Dr. Karl Myers and stands ready to coöperate with them. Carried.

23. **Ethics.**—It was moved by Lowell S. Goin, seconded by Alfred Phillips, that the Council recommend to the House of Delegates that it instruct its delegates to commence to move for an American Medical Association committee on the revision of the Code of Ethics. Carried.

24. **County Hospitals.**—It was moved by Louis Packard, seconded by Howard Morrow, that the Chairman of the Council arrange for representatives of the State Farm Bureau to confer with a committee of the California Medical Association, time and place to be arranged by the committee. Carried.

It was moved by Louis Packard, seconded by Lowell S. Goin, that the Chairman of the Council appoint a committee to represent the California Medical Association in conference with representatives of the State Supervisors Association. Carried.

25. **San Francisco Municipal Employees.**—T. Henshaw Kelly reported for the information of the Council on the plan of medical care for employees of the City and County of San Francisco.

26. **Council Meeting.**—The date of the next Council meeting was fixed as May 8, 1938, at 8 p. m., Hotel Huntington, Pasadena.

27. **Adjournment.**—There being no further business, the meeting adjourned.

MORTON R. GIBBONS, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Program, Annual Session.*
2. *Reduced Railroad Rates, Annual Session.*
3. *Is There a Lack of Medical Care?*
4. *Pacific Coast Conference.*
5. *County Society Appraisal.*
6. *California Medical Association.*
7. *What's Wrong?*
8. *Passing Comment.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Developments in Hospital Insurance.*
2. *Contract Practice.*

PROGRAM, ANNUAL SESSION

This issue contains, in supplement form, the official program for the annual session in Pasadena, May 8 to 12. There will also be found in that supplement the annual reports of officers and committees.

Members are urged to read these reports. They summarize the year's activity and acquaint you with the work that is being carried on in behalf of every member. They reveal facts to you and with which you should be familiar. Know your Association. These reports make it possible for you to become reliably informed.

The program for the annual session is an outstanding one. The subjects are timely and will be presented by capable men. Attendance at these general and section meetings will be profitable and well worth the time of every member. Plan to be present. Write to the manager of the Hotel Huntington for your room reservations. A cordial invitation is extended to every member to attend this sixty-seventh annual session.

DELEGATES

A direct and important responsibility rests upon every delegate to read these annual reports. It is essential that he be informed as to their nature and contained recommendations. This information will enable delegates to adequately represent their respective county organizations in the deliberations of the House of Delegates. Delegates should discuss these reports with their county society members in order to gain the reaction and desires of local members. Delegates are expected to express the wishes of their county society and conform to the instructions expressed. A delegate is not an individualist, for he serves and acts for those whom he represents. To record that representation, the delegate must ascertain the desires and opinions of his constituents.

INVITED GUESTS

For each annual session four out-of-state distinguished clinicians are invited to participate in the scientific program. Our Association has been honored this year by the acceptance on the part of four well known and distinguished medical men of invitations to participate in the program of our sixty-seventh annual session, in Pasadena, May 8 to 12. The following invited guests constitute the group:

Udo J. Wile, M.D., Ann Arbor, Michigan, Professor of Dermatology and Syphilology, University of Michigan Medical Department.

Alfred Blalock, M.D., Nashville, Tennessee, Professor of Surgery, Vanderbilt University.

T. R. Harrison, M.D., Nashville, Tennessee, Professor of Medicine, Vanderbilt University.

Alexis F. Hartmann, M.D., Department of Pediatrics, Washington University, St. Louis, Missouri.

* All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

GENERAL MEETINGS

The opening general meeting on Monday at 10 a. m. will be addressed by President Howard Morrow and Dr. Udo J. Wile of the University of Michigan.

The general meeting on Tuesday will be devoted to a clinical pathological conference conducted by Drs. Alfred Blalock and T. R. Harrison of Vanderbilt University.

The third general meeting, on Wednesday morning, will be addressed by Dr. Alexis F. Hartmann of St. Louis, Missouri, and by Dr. C. Frederic Fluhmann of Stanford University (by invitation).

These three general meetings afford opportunities to hear six outstanding presentations that will be of extraordinary interest and value.

MEETING PLACE

All sessions of the California Medical Association will be held in the Huntington Hotel. Registration, scientific and commercial exhibits will be located in the Patio, which will be covered by a canvas. This will transform the Patio into a very excellent exhibition center. Hotel reservations may be secured through direct communication with the manager of the Huntington Hotel.

ATTENDANCE

With 2,300 members resident in Los Angeles County, it is anticipated that the registration and attendance will be the largest in the history of the Association. Every member able to do so should embrace this opportunity.

REDUCED RAILROAD RATES, ANNUAL SESSION

Those planning to go to the annual session in Pasadena by train are entitled to reduced fare. To obtain this reduction it is necessary to present an official certificate to the agent at the time when you purchase your round-trip ticket. This certificate may be obtained by sending a *stamped* self-addressed envelope to the office of the State Secretary. Remember, a certificate *is necessary*. Send for it today.

RAILROAD FARES

Following are examples of round-trip convention fares from points named below to Pasadena, California, available on presentation of this form of certificate:

Auburn	$15.05	Paso Robles	8.20
Bakersfield	5.55	Redding	19.05
Barstow	4.00	Sacramento	13.95
Calexico	7.50	Salinas	11.15
Chico	16.85	San Bernardino	1.80
El Centro	7.50	San Diego	4.10
Fresno	8.80	San Francisco	14.60
Los Angeles	.40	San Jose	13.20
Marysville	15.55	San Luis Obispo	7.15
Merced	10.45	Santa Barbara	3.55
Modesto	11.60	Stockton	12.50
Needles	9.05	Tulare	7.45
Oakland	14.45	Visalia	7.75
Oroville	16.35	Woodland	14.50

IS THERE A LACK OF MEDICAL CARE?

It is axiomatic that for a satisfactory solution of a problem there must be a clear understanding of the nature of the problem. Impinging facts and factors must be compiled and plans for remedying unsatisfactory conditions must be based upon dependable evidence.

For several years there has been much talk and many statements issued asserting that there was a widespread condition in which many people were without medical care. Some went so far as to state that from 30 to 40 per cent of the population of this country were being deprived of medical care. More lately certain governmental agents, economists and social workers have persistently repeated such statements, and as far as could be learned their statements were supported by few and questionable facts. To those who are earnestly concerned and interested, the instances cited were not convincing, nor were they felt to be dependable. In many of the statements it was apparent that these analyses and conclusions presented evidence that they had been formulated to conform to the preconceived opinions, ideas and purposes of certain individuals and probably distorted to serve personal quests.

A few years ago the American Medical Association made a limited inquiry. Contacts were made in different parts of the country with mayors, supervisors, welfare agents, commissioners and legislators. These public officials were asked if they knew of any person who had died or had been forced to go without medical care. Also, if they knew anyone or any group in their community that lacked medical care. This inquiry did not uncover any person or community that needed or couldn't obtain medical care and service.

In the last year or two there have been additional surveys by individuals or groups. As a result there has again arisen a number of statements reaffirming the existence of the lack of medical care for a large percentage of a given population. The manner in which these surveys were made, the incompetency of many of the investigators, and field workers, the manner in which data was compiled and the inaccuracies of the conclusions created lack of confidence. Trained, competent statisticians and economists were unwilling to accept the data that was presented. To them the findings did not warrant the facts claimed, and these experienced, competent authorities were unconvinced that the conditions were as they were represented.

More recently, and from several and varied sources, the declarations have been more widespread and persistent that many people were in want for medical care. Statements were and are being made that the medical profession through its several organizational units was stubbornly refusing to recognize the situation. That it was assuming a "stand pat" rôle. That is was acting as "obstructionist." That it declined to act. It was told to do something to correct conditions or that it would be done for them.

The traditions of the medical profession unfailingly demonstrate that medical men and accredited medical organizations have always held the health welfare of the people as their chief concern. The quest has always been to safeguard and enhance the health needs of the public individually as well as collectively. In true humanitarianism it has served in meeting and administering to the medical needs of mankind.

True to those traditions and earnestly desirous of ascertaining whether there does exist a lack of medical care for groups of people and to establish or disapprove that statement with accuracy and dependability, the American Medical Association, through its constituent state and county units, will undertake a study and survey as to the availability of medical care in this country.[1]

PLAN OF SURVEY[2]

As outlined in the article to which reference is given, complete survey blanks will be sent to every state organization. State organizations will perfect the details with their county units. County societies, through their members, will secure the local findings requested in these blanks. These will then be collected and returned to the American Medical Association Bureau of Economics. Definite instructions will be sent to each county secretary as soon as the Bureau of Economics forwards these supplies.

It can be confidently expected that the information obtained will be compiled, findings tabulated and conclusions formulated by the most competent, unbiased and experienced statisticians and analysts. Thus there will be made available, for the first time, a true picture of actual conditions and needs. Possessed of these facts, if the need is shown, the American Medical Association and its units will devise the means, as it alone is capable and competent to do, to remedy any untoward conditions and continue to make medical care available wherever it is needed.

Pending the presentation of these facts ill advised and unwarranted plans should be held in abeyance and discouraged.

PACIFIC COAST CONFERENCE

On Sunday, February 27, by invitation from our Association, representatives from the state medical organizations of Washington, Oregon and California met in conference in San Francisco. The following were present:

Elijah Clements Leach, M.D., Arlington, Washington.

Myron S. Jared, M.D., 1215 Fourth Avenue, Seattle, Washington.

Charles E. Hunt, M.D., 132 East Broadway, Eugene, Oregon.

Regner W. Kullberg, M.D., 9 Pacific Avenue, Astoria, Oregon.

[1] See p. 77b, *Journal of the American Medical Association*, February 12, 1938.

[2] *Ibid.*

Mr. Clyde Coley, Medico-Dental-Building, Portland, Oregon.
Charles Edwin Sears, M.D., 1020 South Taylor Street, Portland, Oregon.
Charles Sweeney, M.D., 35 North Central Avenue, Medford, Oregon.
John H. Fitzgibbons, M.D., 812 Southwest Washington Street, Portland, Oregon.
Morton R. Gibbons, M.D., 350 Post Street, San Francisco.
Vincent Askey, M.D., 1930 Wilshire Boulevard, Los Angeles.
Axcel E. Anderson, M.D., 1759 Fulton Street, Fresno.
Karl L. Schaupp, M.D., 490 Post Street, San Francisco.
T. Henshaw Kelly, M.D., 490 Post Street, San Francisco.
Louis A. Packard, M.D., 1412 Seventeenth Street, Bakersfield.
John Ruddock, M.D., 1930 Wilshire Boulevard, Los Angeles.
Henry S. Rogers, M.D., 159 Kentucky Street, Petaluma.
John H. Graves, M.D., 977 Valencia Street, San Francisco.
Howard Morrow, M.D., 384 Post Street, San Francisco.
Charles A. Dukes, M.D., 426 Seventeenth Street, Oakland.
F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco.

Medical, organizational, legislative, and economic subjects occupied the nine hours devoted to this conference.

Those in attendance were so impressed with the value of the conference that it was decided to hold a similar one in Portland, Oregon, early this fall.

COUNTY SOCIETY APPRAISAL

As yearly visits to county societies continue, facts become outstanding and impel certain conclusions. The county society becomes a county institution and a factor in community life when its members mingle with one another in harmony and clear understanding. There we find the nonexistence of individual or small coterie ambitions and selfish quests. The spirit of "the good of the whole" predominates. Public confidence is established and local agencies and officials seek, accept and are guided by the recommendations of the county society in matters related to public health welfare and wide problems of the care of the sick and the conservation of the health of well peoples. Such societies discharge their responsibilities to promote the science and art of medicine and the betterment of the public health. The members are friendly, happy and progressive. That county society is a going organization.

Now let us look at the county society where the opposite to these conditions predominates. The members are split into factions and strife and discord exist. Malpractice suits are numerous. Public confidence is wanting. Health standards are lower. Lay persons and public authorities handle health matters on a political program, ignoring the medical profession. The county society meetings end in discord. The society does not acquit itself of its responsibilities. The doctors lose out collectively and individually. They ignore their shortsightedness and moan unto themselves, but do nothing to rectify conditions.

To these latter it should be said that "medicine without ideals and without ethics ceases to be a profession." The light should dawn upon them that their future depends upon unity and solidarity. Cease bickering! Set about to place your county society house in order.

CALIFORNIA MEDICAL ASSOCIATION

6,008 Licensed Physicians and Surgeons

39 County Organizations

9 Councilor Districts

House of Delegates
(149 delegates chosen by the membership)

Council
(23 members)

Executive Committee
(8 members)

23 Standing and Special Committees

12 Scientific Sections

The foregoing reveals the democratic and representative plan of organization of your State Association. Work for it by loyal coöperation.

WHAT'S WRONG?

At Association Nights, when Association officers visit county societies and discuss organizational activities and professional problems and interests, there is always an "after-gathering" for personal discussions. At these "after-sessions" groups gather round and present personal questions or express individual opinions. At one of these sessions a member put the question—"What is wrong with our profession?" The answer given was "Nothing."

Centuries ago, one Hippocrates formulated certain principles that he condensed into a pledge or oath which medical students swore to and then some forgot. Let us quote certain sentences:

> I will prescribe regimen in order to benefit the sick, and not do to them injury or wrong. . . . In holiness and righteousness I will pass my life and practice my art. . . . Into whatever house I enter, my entrance shall be for the benefit of the sick, and shall be void of all intentional injustice or wrongdoing. . . . I will keep silence, judging such silence sacred.

Now turn to the history of the centuries that have gone before. Scan its pages carefully. There appears an ever-increasing galaxy of men of medicine who not only led, but also served the physical needs of the people of their day. And, serving, they met the problems of the hour and labored to refine and unfold the hidden mysteries of our medical science and perfected the art of its application. Thus, through their contributions and precepts, our profession, its theories and practices, its science and knowledge, reached the present standing and place in our social world.

And what a glorious record has been made for medicine and its practitioners! There is no greater romance than the romance of medicine. No emergency ever arose, no pestilence or calamity occurred, no war was ever waged and no community ever existed in which the practitioners of medicine failed to serve with their fullest ability and capacity to meet the medical needs of the people. They never failed to respond to the call of humanity. The record of service is truly one of honor and, shall we not say, righteousness and holiness.

This passing comment will not permit the citing of specific illustrative instances of which there are scores on scores of outstanding occasions. Whatever has been good for the health needs of the people has come forth from within the ranks of the profession, and never from outside agencies. Whatever progress has been made has been inspired and developed by our own students, men of research, investigators and members. Whatever were the medical needs of any emergency in any community, county, state or the nation, accredited representatives from within the profession formulated and applied the solution. When, a few years ago, there were some who asserted that people were in want of medical care the investigations and inquiries revealed that such assertions were unfounded and without warrant. True, there are those who prefer not to avail themselves of the ministrations of physicians, and, again, there are those whose intelligence is of such low grade that by reason of their ignorance they do not seek medical services that are available. That situation cannot be used as a criticism of our profession. The point is being made that none need to be without medical advice and care.

Then why the query that is being heard—"What is wrong?" The answer remains—"Nothing!"

If we enter into generalities the same query may be advanced for the social and governmental conditions that

confront us today. While the answer is apparent, many ignore and avoid it. It is not purposed to advance the answer other than to the query that relates to medicine, physicians and medical care.

The things that are wrong with medicine, if they can be designated as "wrongs"—it is preferable to refer to them as delay in readjustments—may be tabulated thus:

1. Jittery instability and nonobservance of fundamentals.
2. Quests on the part of ill-informed and unadvised, inexperienced individuals outside the ranks of medicine who seek to reform, reshape and direct our labors and our destiny.
3. Wavering on the part of physicians who seek to desert time-tried principles and ignoring them endeavor to follow self-constituted principles.
4. Nonobservance of the principles of ethics.
5. Financial greed.

There will be nothing wrong if men of medicine recall and observe Hippocrates' last exhort—"If, then, I fulfill this oath and do not violate it, may I enjoy my life and art and be held in honor among all men forever; but if I transgress and prove false to my oath, then may the contrary befall me."

There is nothing wrong, for, true to our traditions, chosen representatives in our organizational ranks will present and apply required solutions. May individuals conform to them!

PASSING COMMENT

In serious accidents, a consultant's note on the hospital record will refute and defeat many malpractice claims. Seek consultations often.

* * *

Settlement in malpractice claims stimulates additional claims. Demand trial and, when necessary, appeal to the highest courts. Observance of this policy will eventuate in lessening the number of claims and suits and also reduce premium rates.

* * *

Have you paid your dues for the current year? If not, remit them to your county secretary today. Failure to do so places your name on the suspension list and that means that this will be the last issue of your Journal that you will receive until you are reinstated. Pay your dues today.

* * *

Read the annual reports of the Supplement of this issue. They enlighten you upon organizational activity.

* * *

Suit was brought by a correspondence school to collect on a note given for a study course. Defendant filed a cross petition for damages for pain and anguish suffered by reason of a series of letters, notes and warnings sent to him. A $500 judgment was given. In another case the debtor sued for damages for mental pain, anguish and humiliation which she claimed to have suffered by reason of a series of letters written her. The court, in sustaining a verdict giving damages, stated that the letters were a willful intent to produce pain and mental anguish.

Hence the warning to be careful as to how you write debtors in demanding payment. Apparently there can be greater pain and anguish than that caused by having to pay one's bills.

* * *

We must deal collectively with the exploitation of our profession and the services it renders. Much depends upon how county societies and individual members act. Unity of purpose and action is the most effective method for safeguarding the future of our profession.

* * *

At one time in the history of organized medicine there was a certain group of members in almost every county unit who appeared to think their highest duties were performed when they succeeded in carrying the yearly elections through satisfactorily, and had the newly elected officers duly announced in all the daily papers. While this class of members is not entirely extinct, the vast majority of members appreciate the educational value of every meeting and regularly attend all meetings of their county and state associations. A member can obtain as much from his society as he desires. The greater his personal contribution, the greater his returns. Your society will be just what you help make it to be as an active medical organization.

* * *

"To whom shall be given the honor of a discovery? This question can never be answered fully; science is a continuous process; each investigator must of necessity build on the work of those who come before him. What we know, what we think we know, and what we think is a stream which flows by us and through us, fed by the far-off rivulets of long ago."—Sir Michael Foster.

* * *

Are you concerned with a problem? If so, write to your State Association headquarters. An earnest endeavor will be made to be of assistance to you and send you the information you desire to secure if it is at all possible to do so. It is your headquarters office and its services are at your disposal as one of the benefits of membership.

* * *

It would help a lot if every member would ask the detail men who call upon them whether his firm advertises in your state journal; if not, why not; and that you give preference to your advertising patrons. Please coöperate.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Developments in Hospital Insurance

The following is from the *Journal of the American Medical Association,* issue of February 26, 1938:

A statement issued by the trustees of the Intercoast Hospitalization Insurance Association of Sacramento, California, describes the changes in the five years of operation of this hospital insurance plan and affords a forecast of the developments in hospital insurance.

Based on a careful study by an actuarial specialist and an examination report by the state insurance commissioner, it was found that the association was financially sound, but that insufficient reserves were being accumulated to make the organization permanently stable. In order to increase reserves it was suggested that either the cost of the policy to the member be increased, the services allowed to be decreased or the two methods be combined. The trustees of the Intercoast Hospitalization Insurance Association felt that an increase in the policy premium, which is $1 monthly or $11 annually, would prevent a large group of persons from becoming members. Therefore, partly as a result of the necessity to improve the reserve status and partly because of the objection to the inclusion of x-ray and laboratory services in a hospitalization policy by the California Medical Association and the American Medical Association, the trustees of the Intercoast Hospitalization Insurance Association voted to eliminate both x-ray and laboratory services from future contracts. The amount of services provided for women and children was also reduced by 25 per cent, with the exception of employed women enrolled as a group by means of payroll deductions. In addition, the contracts of 350 members were canceled as poor risks, and special limiting riders will be attached to the contracts of other members who are considered doubtful risks. In 1936 all provisions for maternity care were discontinued, although this action caused 2,654 members to drop their policies.

These changes were deemed essential to the financial stability of the Intercoast Hospitalization Insurance Asso-

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

ciation and were made in accordance with the best experiences of this hospital insurance plan, which has been operating as long as any free choice group hospitalization plan in the United States.

It has long been contended by the medical profession that the inclusion of medical services in a group hospitalization contract is undesirable because of the disturbing effect on the practice of medical specialties in hospitals, such as anesthesia, pathology and radiology. It now appears that another good reason for excluding these medical services from hospital service contracts is presented by insurance actuaries, namely, that a proper premium to provide for medical services cannot be calculated in advance. Because of these two conditions, there are several indications that hospital service corporations are contemplating the exclusion of medical services from renewals of existing contracts and from all future contracts.

Contract Practice

It is apparent that there are members of our profession who are not informed as to the principles of medical ethics that relate to contract practice. For their information the following sections are quoted:

REVISED PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION—1937

Conditions of Medical Practice

Sec. 2. It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public or to the individual physician, and lowers the dignity of the profession.

Contract Practice

Sec. 3. By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not per se cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

Direct Profit to Lay Groups

Sec. 5. It is unprofessional for a physician to dispose of his professional attainments to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

County medical societies are the designated censors of their members. The responsibility rests with the county society to enforce observance of these principles.

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of March 3 at the General Hospital, with President Francis Stump presiding. Fifteen members were present, and two visitors—Dr. Charles Sweeney, President of the Oregon State Medical Society, and Dr. Charles Lemery, both of Medford, Oregon.

Doctor Sweeney spoke on *Salient Points of Abdominal Surgery*, and Doctor Lemery's topic was *Early Symptoms, Diagnosis, and Treatment of Glaucoma.* Both papers were very well presented.

After an enjoyable luncheon, the meeting adjourned.

LAWRENCE A. WING, *Secretary.*

KERN COUNTY

The Kern County Medical Society met at the Taft Hotel in Taft on Friday evening, February 18. President Harry Lange called the meeting to order.

On the motion of Dr. H. W. Jones, seconded by Dr. Seymour Strongin, it was voted that the minutes of the Board of Directors' meetings be read at the regular society meetings so that members may be better informed regarding transactions of the Society. It was also voted that a committee be appointed by the president to determine whether the physicians' telephone exchange service should be continued in Bakersfield. A committee, consisting of Doctors Garner, McAllister and Dykes, was appointed by the president to arrange special listing of the Taft members in the Taft telephone directory, as has been done in the Kern County telephone directory with other members.

The speaker of the evening was Dr. Clyde Emery, Chief of the Department of Roentgenology at Cedars of Lebanon Hospital in Los Angeles. Doctor Emery spoke on *Use of Radium and X-ray in Malignancy.*

An excellent dinner was enjoyed by the seventeen members present. Heavy rain prevented many members from attending this annual meeting in Taft.

C. S. COMPTON, *Secretary.*

MARIN COUNTY

At the regular February meeting of the Marin County Medical Society, held at the Marin Golf and Country Club, both the members of the Society and the Woman's Auxiliary enjoyed a very interesting discussion by Dr. Chauncey Leake of the University of California Department of Pharmacology, on *The Drugs Commonly Used in Medical Practice.*

CARL W. CLARK, *Secretary.*

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Dave Dozier, on January 18, at the Auditorium on Twenty-ninth and L streets. There were fifty-four members and guests present.

Dr. H. M. Kanner presented the paper of the evening. His subject was *The Treatment of Gonorrhea in Women.* Doctor Kanner stated that, on the whole, the treatment of this disease is unstandardized and unsatisfactory. The subject was taken up first as to the general measures used, such as bed rest, cleanliness, and abstinence; then the treatment of the points of infection in the child and the adult. Doctor Kanner stressed the treatment of the Bartholin glands by use of the electric needle early when these glands are affected, and to cauterize and pack the gland is better than attempting to enucleate in case of abscess formation. In treating the cervix, do not overtreat. Irrigations seem to be of most value, along with linear cauterization. Doctor Kanner stated that he did not use tampons, feeling that they are of no value and interfere with proper drainage. The value of the Elliott treatment or similar machine was stressed in treatment of pelvic inflammatory infections. Lantern slides showing some of the author's statistics, as well as pictures of the various types of machines used for heat therapy, were shown. The paper was very instructive,

and presented in an interesting manner. Discussion was opened by Dr. E. O. Brown, and continued by Doctors Beach, Turner, McDonnell, and Ed Babcock.

Under new business, Dr. C. Ankele presented a resolution regarding fee splitting to industrial accident insurance companies. A motion was made, and seconded, that the resolution be accepted. The motion was lost (17 for, 24 against). Doctor Turner then made a motion that we submit the resolution to Mr. Hartley Peart for revision, and that the revised resolution be read at the next meeting. The motion passed.

Doctor Dozier read the names of the members composing the committees for the year 1938.

G. E. Millar, *Secretary.*

SAN BERNARDINO COUNTY

The regular meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, March 1. About seventy-five members and guests were present.

In the absence of Dr. W. W. Fenton, County Health Officer, the Secretary was called upon to outline the plans to date for the contemplated venereal clinic.

The house in the two hundred block on Fourth Street in San Bernardino was found suitable by Doctors Davey and Stoudt of the State Department of Public Health; the rental is $50, to be paid by the county, and the county's only expense for the clinic. The plans are to start the clinic about April 1, with Dr. J. W. Moreland in charge. Consultants have not been appointed, and are to serve without pay. Besides Doctor Moreland, the personnel will include a well-trained nurse, orderly, and secretary, who will be capable of doing the Social Service work. These are all to be Civil Service employees. The State will spend between $1,500 and $2,000 to equip the clinic. Follow-up nursing is to be aided by the Public Health nurses in the cities and county. The name of the clinic will probably be "The Health Center."

Doctor Hilliard asked about the minimum fee to be paid by those able to do so, and receive treatment my private physicians. The Secretary explained that this was to be determined by the Society.

Doctor Savage, Jr., asked about adequate social service. This is to be done by the Secretary, who it is hoped will be capable of doing this work in addition to her secretarial work.

Doctor Abbott made a plea for keeping the clinic at the hospital for adequate social service, consultation, etc. He asked the coöperation of the Society in the aid of the clinic's success.

The scientific program was given as follows: *Obesity*, Dr. E. Kost Shelton of Los Angeles. Discussion was opened by Dr. Justin Neighbor and Dr. C. A. Wylie, followed by questions and general discussion.

The venereal clinic was then discussed again, and Doctor Hilliard made a motion that the Society instruct a committee to investigate the matter further and to report to the Council to take such action as they saw fit to formulate a policy to be followed in this matter. The motion was seconded, and passed.

Doctor Abbott suggested that the Standing Committee on Public Relations and Public Policy be instructed to do the necessary work, in place of a new committee. This met with general approval, and Doctor Abbott was ordered by the President to call a meeting of this committee.

The meeting adjourned at 10 p. m., following which refreshments were served.

Arthur E. Varden, *Secretary.*

SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was called to order by the president, Dr. A. C. Boehmer, at 8:15 p. m., in the Medico-Dental clubrooms, Stockton. The meeting was preceded by the customary supper meeting, held at the Hotel Wolf, at which twenty-five members and guests were present. The paper of the evening was presented by Dr. A. K. Merchant of Stockton, who talked on *Treatment of Gastric Malignancy by X-ray.*

The application of J. J. Seibel of Lodi for membership in the San Joaquin County Medical Society was reported on favorably by the Admissions Committee, and there being no objections from the floor Doctor Seibel was declared a member. Petition of affiliation to the San Joaquin County Medical Society of Dr. Curtis M. Galt of Manteca was received. This application was referred to the Admissions Committee for action.

Doctor Broaddus spoke on the Postgraduate Study group and presented certificates to those who had completed the course. Under miscellaneous business, President Boehmer urged all members of the San Joaquin County Medical Society to attend the memorial services for past president Thomas O'Conner, which are to be held at Bret Harte on Sunday, March 6, at 2:30 p.m.

The Secretary urged payment of dues by members who have not as yet paid their dues, advising them that they would be declared delinquent if the dues were not paid in time for transmittal to the California Medical Association on or before April 1.

The papers of the evening were presented by Dr. Carl Mathewson of San Francisco, Associate Professor of Surgery at Stanford, whose paper was on *Diagnosis and Treatment of Lymphogranuloma Venera.* Doctor Mathewson announced that he would furnish Frei antigen to those interested, for use and diagnosis in this condition if they communicated with him at the San Francisco County Hospital. This paper was profusely illustrated by slides. Dr. Robert Scarborough of San Francisco, Associate Professor of Surgery at Stanford, read a paper on *Cancer of the Rectum,* and suggested early diagnosis and treatment. Both papers were very well received and caused considerable discussion.

Mr. Hunter, special agent from the State Board of Medical Examiners for the northern part of the State, was introduced to the Society and stated that he would be glad to be of any help to the members. There being no further business to come before the Society the meeting was adjourned at 10:45 o'clock, and refreshments served.

G. H. Rohrbacher, *Secretary.*

SANTA BARBARA COUNTY

The month of February has been unusually active. A special meeting was held on February 7, attended jointly by the Santa Barbara and Ventura County Medical Societies. Officers of the California Medical Association were present and contributed to the program, the purpose of which was a relation of the Association's activities and the establishment of a rapport with the local societies. The speakers were Councilor Louis Packard, President-Elect Roblee, and Secretary Warnshuis.

On February 14 the regular monthly meeting was held. Prior to the business meeting, the Society members enjoyed dinner with the members of the Santa Barbara Bar Association. The speakers were: Mr. W. G. Gilbert, who spoke on *Some Aspects of Medical Jurisprudence,* and Dr. G. V. Hamilton, who spoke on *The Hypothetical Question.* At the business meeting a committee was formed to draw up resolutions regarding the death of Doctor Loveren. The Society voted that all members should join the Public Health League. New members elected were Dr. Clark Brown and Dr. Helen Hart.

The activities for the past month have in no way mitigated the Society's sorrow over the death of Dr. George Stillman Loveren. Kindly and self-sacrificing, he was respected and loved by all who knew him. His passing on the morning of February 3 seemed almost as though one had lost something out of one's own life. His buoyancy and humanity made even a casual "hello" stimulus to brighten one's day.

J. Jerome Rupp, *Secretary.*

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held on January 11 at the Ventura County Country Club at Saticoy.

There were seventeen members present. Doctors Witten, Moore, and Gilman, of the County Hospital, were guests.

A brief report of the progress being made by the Committee on Prepaid Medicine was given by Dr. Charles Smolt. After meeting with the Council of the California Medical Association, it was found that the plan which the

committee had previously presented to the Society would probably not be legal.

Following a discussion of this subject, Doctor Homer made a motion that the committee continue to investigate various plans in an attempt to present a suitable plan. Also that the members of the committee be reimbursed for their expenditures for tours. The motion was seconded by Doctor Shore. The motion carried.

Doctor Smolt asked for suggestions as to the best manner in which to draw up a fee schedule. It was suggested that the committee present some type of schedule and then let the members amend it.

Doctor Little cited a case in which a public health nurse had referred the patient directly to the County Clinic instead of his office. He was reassured by Doctor Wylie that an effort would be made to prevent a recurrence of this situation.

Doctor Wylie spoke briefly on the rabies quarantine which is now in effect in Ventura County, and gave the reasons for its necessity. Doctor Nielsen made a motion that the Society support Doctor Wylie in maintaining this quarantine and that this action be published in the various newspapers throughout the county. The motion was seconded by Doctor Homer, and was unanimously carried.

Doctor Shore made a motion, seconded by Doctor Smolt, that the Society endorse the plan for hospital insurance as offered by the Associated Hospitals of Southern California. The motion carried.

In accordance with the communication from Doctor Warnshuis asking if it would be possible for us to arrange a joint meeting with the Santa Barbara County Medical Society on February 7, Dr. Grant Clark made a motion that we meet with that society on that date. The motion was seconded by Doctor Strong, and carried.

After a short discussion on the value of the work accomplished by the Public Health League, Doctor Smolt made a motion that a special assessment of $5 be levied on each member, to meet the annual dues of this organization. The motion was seconded by Doctor Stoll, and was unanimously carried.

Dr. J. A. Mahan of Oxnard was unanimously elected to membership in this society.

Doctor Witten announced that the internes at the County Hospital were planning to have the Lederle film on the *Diagnosis and Treatment of Pneumonia* shown at the County Hospital on February 9. The members of this society were invited to see this film.

The following committees were appointed by Doctor Coffey:

Board of Censors—Doctors Mosher (chairman), Stoll, and Strong.

Program—Doctors Homer (chairman), Osborn, and Barker.

Public Health and Legislature—Doctors Wylie (chairman), Nielsen, and Gronhovd.

The president and the secretary ex officio.

* * *

In lieu of the regular meeting, a joint meeting was held with the Santa Barbara County Medical Society in the Cottage Hospital auditorium on February 7.

Doctor Lamb of Santa Barbara presided.

The following officers of the California Medical Association addressed the meeting: President-Elect Roblee of Riverside; F. C. Warnshuis, State Secretary; L. S. Goin, Speaker of the House of Delegates; and L. A. Packard of Bakersfield, Councilor of the Third District.

Doctor Henderson spoke briefly on the Postgraduate Conference which is to be held at Santa Barbara on March 12 and 13.

Doctor Profant spoke briefly on the Public Health League. A. A. Morrison, *Secretary*.

YOLO-COLUSA-GLENN COUNTY

The March 1 program of the Yolo-Colusa-Glenn County Medical Society was held at the Hotel Woodland. Ben H. Read, Executive Secretary of the Public Health League, gave a report on *Legislation*. Dr. Don King, Professor of Orthopedics at Stanford University, presented a paper on *Backache*. W. J. Blevins, Jr., *Secretary*.

CHANGES IN MEMBERSHIP

New Members (66)

Alameda County

J. Harold Kay

Butte County

L. A. Jacoby

Fresno County

Ernst Aronstein

Lassen-Plumas-Modoc County

Bernard S. Holm

Los Angeles County

Marshall Q. Baker
Samuel P. Benbrook
George Berger
Edgar H. Brown
Walter B. Brown
Alva L. Bryant, Jr.
Bragg C. Cammack
Rea F. Chittenden
Herbert T. Cox
Samuel P. Danno
J. M. David y Malig
Carl F. Doehring
Harold M. Golden
Samuel Z. Goodman
Jesse L. Henderson
S. B. Ledesma
F. X. McDonald
John F. McKitrick
Herbert S. Nauheim
Albert E. Nelson
Blythe W. Pahl
Louis J. Petritz
E. A. Roehm
Lee P. Rombeau
Theodore Strang
Vernon Van Zandt
Aaron Neal Webb
Carroll W. White
Laurin L. Wood

Merced County

William E. Fountain

Monterey County

H. C. Murphy

Riverside County

P. A. Staley

San Diego County

H. K. Albertson

San Francisco County

Roy Cohn
Emelie Anderson DeEds
Lindol Richmond French
Mary F. Glover
Mark Hand
Siegbert Lazar
Ernst Lohnberg
Patrick J. Mangan
Hans A. Meyer
Charles Edward Smith
George Waters
Richard Renfro Webster
Harry DeNell Williams, Jr.

San Joaquin County

Orvin P. Fry
Harold E. Schwing
J. J. Seibel

Santa Barbara County

Doris McNamara
Sheldon Payne

Santa Clara County

Robert B. Cragin
Clyde B. Conger

Santa Cruz County

John D. Fuller
Avery E. Wood

Siskiyou County

Paul F. Diffenbacher
Albert Bartlet Gray
Francis Whitney Martin
Roy Felix Schlappi

Stanislaus County

Sidney J. Alson
A. P. Von Hungen

Ventura County

John W. Nielsen

Transferred (4)

Milo Ellik, from Santa Clara County to Los Angeles County.

Joseph Langer, from Siskiyou County to San Bernardino County.

John B. McConnell, from San Diego County to Butte County.

Elwin W. Thomas, from Shasta County to San Bernardino County.

Resigned (2)

E. F. Jones, from Alameda County.

Edwin E. Ziegler, from San Francisco County.

In Memoriam

Bowers, Paul E. Died at Los Angeles, February 15, 1938, age 52. Graduate of the State College of Physicians and Surgeons, Indianapolis, 1907. Licensed in California in 1918. Doctor Bowers was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Brinckerhoff, Elmer Ellsworth. Died in Oakland, March 12, 1938, age 55. Graduate of the University of Illinois College of Medicine, 1908. Licensed in California in 1909. Doctor Brinckerhoff was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Loveren, George Stillman. Died at Santa Barbara, February 3, 1938, age 54. Graduate of Jefferson Medical College of Philadelphia, 1907, and licensed in California the same year. Doctor Loveren was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Meneray, Prince Albert. Died at Santa Rosa, March 1, 1938, age 80. Graduate of the Kentucky School of Medicine, Louisville, 1891. Licensed in California in 1893. Doctor Meneray was a member of the Sonoma County Medical Society, the California Medical Association, and the American Medical Association.

✝

O'Neill, Arthur Aloysius. Died at San Francisco, March 2, 1938, age 69. Graduate of Cooper Medical College, San Francisco, 1891. Licensed in California in 1892. Doctor O'Neill was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Putnam, Victor Eugene. Died at San Francisco, March 11, 1938, age 66. Graduate of the University of California Medical School, San Francisco, 1896, and licensed in California the same year. Doctor Putnam was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✝

Russell, William Wallace. Died at San Diego, March 2, 1938, age 47. Graduate of St. Louis University School of Medicine, 1916. Licensed in California in 1922. Doctor Russell was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

✝

Smith, Frank Holmes. Died at San Bruno, February 19, 1938, age 59. Graduate of Cooper Medical College, San Francisco, 1905, and licensed in California the same year. Doctor Smith was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Van Vorhis, James Harrison. Died at Corcoran, February 10, 1938, age 65. Graduate of Northwestern University Medical School, Chicago, 1901. Licensed in California in 1913. Doctor Van Vorhis was a member of Kings County Medical Society, the California Medical Association, and the American Medical Association.

OBITUARY



Milton Ellis Lando
1878–1938

Dr. Milton Ellis Lando, born on February 16, 1878, in San Francisco, died suddenly of a cerebral accident on January 31, 1938. He was a graduate of the Cooper Medical College, now Stanford University Medical School, in 1900. He entered the Army Medical Corps after interning at the Marine Hospital, San Francisco, and was assigned to duty in the Philippine Islands during the reconstruction period after the Spanish-American War, where he saw much active service far from the beaten track of our usual civilization.

He was chief surgeon of the Crocker Total Eclipse Expedition in 1908 to Flint Island in the mid-ocean of the South Pacific, led by Professor Campbell of Lick Observatory.

After this term of service, he entered the Navy Medical Corps until 1910, when his medical interest developed in the field of eye, ear, nose and throat. This led Doctor Lando to Vienna, which was the outstanding center of this specialty at the time. His main interest has always been in diseases of the eye, however, and as his practice developed, his attention was focussed on this particular field, which in later years was his exclusive specialty.

Doctor Lando was not a prolific writer, but had developed a particular knack of giving to lay audiences a comprehensive picture of diseases of the eye. He took much pleasure in, and was a frequent speaker before such groups, helping to publicize the right kind of medical approach toward these problems where there is so much loose thinking among the general public.

He was a member of the Alameda County Medical Society, the California Medical Association, and the American Medical Association. He was also a member of the American Board of Ophthalmology. He was chief of the Eye Clinic at the Children's Hospital of the East Bay. His interest in this work was not confined to the clinic alone, but many hours of his own office time were devoted to working out the problems of these children when the Clinic observations were not quite adequate.

He was a member of Aahmes Temple of the Shrine and other Masonic Orders; of the Moose Club, Oakland Lions Club, and Oakland Lodge of B'nai B'rith. He was chairman of the Committee for the Blind of the Oakland Lions Club, and has done much to alleviate the social conditions, as well as the medical problems arising in this group.

He was much interested in general community problems, and his passing will be a distinct loss to the medical profession as well as the entire community, which he had served so faithfully for these many years.

HAROLD GUYON TRIMBLE, M.D.

✝

Paul Eugene Bowers
1886–1938

Dr. Paul Eugene Bowers died at the Glendale Sanitarium, Glendale, California, on February 15, 1938. Doctor Bowers was graduated from the Indiana University in 1907

and was licensed in California in 1918. He was a member of the Los Angeles County and California Medical Associations, and of the American Psychiatric Association. For eight years he served as medical superintendent of the Indiana State Prison and Hospital for the Criminal Insane at Michigan City, Indiana. In his army service, he was at the Mexican border in 1916, with Indiana troops, and later at the Base Hospital No. 24 at Palo Alto, California. Recently, he was commissioned a senior surgeon in the Reserve Corps, U. S. P. H. S., with the rank of Colonel. He was the author of many articles, appearing in *International Clinics* and other medical journals, on topics related to prison, crime, and psychiatry.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS.....President
MRS. FRED ZUMWALT.....Chairman on Publicity

News Letter

Dear Auxiliary Members:

Make your reservations now for the convention to be held in Pasadena, May 9 to 12. If I could just have the space to tell you of the interesting and delightful days that have been planned for you by Mrs. Newcomb—but that is written in detail for you in the *Courier*. Read the program carefully and then call your friends and *all come*.

Cordially yours,
MRS. FRED H. ZUMWALT.

Official Business

Report of the State Board Meeting.—A special session of the officers and Board of Directors of the Woman's Auxiliary to the California Medical Association was held at the Hotel Huntington, South Oak Knoll, Pasadena, on Wednesday morning, February 23, at nine o'clock.

The state president, Mrs. Hobart Rogers of Oakland, presided. The attendance was unusually large, all of the state officers—Mesdames Frederick N. Scatena, Elliot G. Colby, H. E. Henderson, Charles C. Hall, Harry O. Hund, as well as the councilors-at-large, Mesdames William W. Roblee, Arthur T. Newcomb, A. E. Anderson, and Fred H. Zumwalt—were present. The following district councilors attended: Mesdames Dexter R. Ball, Benjamin H. Sherman, Ed L. Markthaler, Lawrence Knox, Harold Trimble, and George A. Briggs. County presidents Mesdames Eliot Alden of Los Angeles, G. Wendell Olson of Orange, T. A. Card of Riverside, and W. J. Van Den Berg of Sacramento, were also present. Three members of the Board are, in addition, county presidents: they are Mrs. A. E. Anderson of Fresno, Lawrence Knox of Monterey, and Elliot G. Colby of San Diego.

President-Elect Mrs. Clifford Andrews Wright of Los Angeles was present. As in the past, our leaders have been women of exceptional ability and sane judgment; so, too, of the future we need have no fear with Mrs. Wright at the helm.

The most important business considered was the approaching convention of the California Medical Association to be held in Pasadena, May 9 to 12, with headquarters at the Hotel Huntington, South Oak Knoll, Pasadena. All meetings of the Auxiliary will be held at the Vista del Arroyo in Pasadena. Mrs. Arthur T. Newcomb, Convention Chairman, presented in detail the plans of her committee, which met with the hearty approval of the Board.

Mrs. Frederick N. Scatena, Chairman of Membership and Organization, reported the organization of Butte, Santa Cruz, and Tulare counties, the two former having sent in copies of their constitutions and by-laws.

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

The *Hygeia* chairman, Mrs. Harold G. Trimble, reported a total of 443 subscriptions, all but two of the counties having replied.

The other chairmen gave interesting reports of their activities, proving that the year has been an unusually profitable one.

Following the meeting the members of the Board and the county presidents were entertained at a delightful tea in the Vista del Arroyo Hotel. The hostesses were Mrs. Arthur T. Newcomb of Pasadena, Mrs. Benjamin H. Sherman of Hollywood, and Mesdames Eliot Alden and Mark Glaser of Los Angeles.

Component County Auxiliaries

Contra Costa County

Fifteen members were present at the last meeting of the Woman's Auxiliary to the Contra Costa County Medical Society. Renewed interest seems to be shown, and before long we hope to report a large enrollment.

MRS. MELVIN L. STAUFFER, *President.*

Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association held its regular luncheon meeting on Tuesday, February 22, at the County Medical Building, with Mrs. Eliot Alden presiding. Ninety-three members were present.

Guests of honor of the occasion were visiting members of the State Board, including Mesdames Hobart Rogers, Fred H. Zumwalt, Elliott E. Colby, Charles C. Hall, and Harry O. Hund.

The guest speaker was Dr. Paul Perigord of the faculty of the University of California at Los Angeles, who talked on *The Triumphant Power of Ideals.*

On Wednesday, February 23, the State Auxiliary Board, the Convention Board, and the Los Angeles County Board were guests at a tea given by Mrs. Arthur T. Newcomb, Mrs. Benjamin H. Sherman, Mrs. Mark A. Glaser, and Mrs. Eliot Alden, at the Vista del Arroyo Hotel in Pasadena. Tea was served from a charmingly appointed table, decorated with a profusion of spring flowers in pastel shades.

MRS. ROBERT L. CARROLL, *Corresponding Secretary.*

Marin County

The February meeting of the Woman's Auxiliary was held, as usual, in the form of a dinner meeting at the Marin Golf and Country Club on Thursday, February 24. Our guest speaker was Dr. Chauncey Leake, Professor of Pharmacology at the University of California. Such an interesting meeting had been planned that we invited the medical society to join us. Briefly, the history of the physician, the surgeon, and the apothecary was outlined by Doctor Leake, who spoke on the subject planned for the evening, *Drugs and Society*. One of the important points stressed was that vitamins are drugs, and as such can be given, in some cases, in too large doses.

We were honored by having Mrs. Leake with us also.

Later in the evening the Auxiliary held a short business meeting. The secretary presided, as both the president and the vice-president were unable to be present.

MRS. B. J. CONROY, *Chairman of Publicity.*

Orange County

The Woman's Auxiliary to the Orange County Medical Society met on Monday, February 21, at the home of Mrs. John Wehrly of Santa Ana for their regular meeting and formal tea honoring our state president, Mrs. Hobart Rogers; corresponding secretary, Mrs. Charles Hall; Chairman of Program and Health Education, Mrs. Elliot G. Colby; and the First District Councilor, Mrs. Dexter Ball.

The president, Mrs. G. Wendell Olson, presided at the meeting. Mrs. Rogers, upon introduction, responded by outlining, in an interesting and inspiring manner, the aims and purposes of our organization and the importance of the Auxiliary to the county, state, and national organizations. Mrs. Charles Hall and Mrs. Elliot Colby responded also, upon introduction.

Mr. Calvin Flint, dean of men at Santa Ana Junior College, spoke on *Europe Awakens to Hygiene*. He was presented to the members by Mrs. K. H. Sutherland.

Tea was served at the close of the meeting. Hostesses assisting Mrs. Wehrly were Mesdames Thomas Rhone, E. L. Russell, and Fred Earel.

Mrs. G. Wendell Olson, *President.*

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Riverside County

Mrs. Hobart Rogers of Oakland, President of the Woman's Auxiliary to the California Medical Association, and Mrs. Charles Hall of Piedmont, State Corresponding Secretary, were honored guests of the Riverside County Auxiliary on Friday, February 18, at a luncheon meeting. Sixteen were present for the event, which was held at Ye Olde South Tea Room.

Corsages of spring flowers were presented to the guests, and other colorful blossoms adorned the table. Mrs. T. A. Card, President, presided over the business session.

Mrs. Rogers addressed the group on the work of the Auxiliaries throughout the state and nation.

Mrs. H. J. Wickman, *Corresponding Secretary.*

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Sacramento County

Legislation Pertaining to Medicine was the subject of the address given by Dr. J. B. Harris before the Woman's Auxiliary to the Sacramento Society for Medical Improvement at its evening meeting on February 15 in the home of Dr. and Mrs. A. M. Henderson.

Facts given by Doctor Harris were enlightening and interesting. He called attention to the important work which the Auxiliary members can do in helping to further the cause of proper medical legislation.

A business meeting followed, at which the Nominating Committee presented its report of nominees for 1938. The committee is composed of the following members: Mrs. Frank A. MacDonald (chairman), Mrs. Harry M. Kanner, and Mrs. John D. Lawson.

Hostesses who assisted Mrs. Henderson were: Mesdames John L. Fanning, F. F. Gundrum, C. B. McKee, Norris Jones, D. Schuyler Pulford, Herbert True, and C. E. von Geldern.

Mrs. Hugh Carmichael, *Chairman of Publicity.*

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San Diego County

The Woman's Auxiliary to the San Diego County Medical Society met on March 8 at the Men's University Club for its regular luncheon meeting. Mrs. T. S. Whitelock, Jr., and Mrs. J. G. Omelvena arranged very lovely flowers and decorations.

Dr. Lyell C. Kinney spoke on *Legislative Problems.* He brought to the attention of the Auxiliary three very important initiative measures to be brought up this coming November. These measures will undoubtedly greatly affect the practice of medicine. The first, the "Humane Pound Act," threatens the advancement of medical science through the prohibition of animal experimentation; the second, "County Hospital Act," will open hospitalization, medical attention, and dentistry to every one, irrespective of means, in the county; and third, the "Public Health Liability Act" will make a wrong diagnosis in surgery a crime punishable by $500 fine and six months' suspension of license. These serious problems will indeed need our support and study.

Mrs. R. E. Bond, *Secretary.*

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San Francisco County

Dr. William C. Voorsanger, President of the San Francisco County Medical Society, honored the Auxiliary with an address at the regular meeting on March 15 at 2180 Washington street. *The Medical Profession's Present-Day Problems,* was Doctor Voorsanger's subject for the afternoon. The president, Mrs. Hans Barkan, presided.

Following the program, a short business session was held, including a report from the Nominating Committee, as follows: Mrs. Thomas E. Gibson, president; Mrs. Edmund J. Morrissey, first vice-president; Mrs. A. Lincoln Brown, second vice-president; Mrs. Fred D. Fellows, recording secretary; Mrs. Wilber F. Swett, corresponding secretary; Mrs. John D. Humber, treasurer; Mrs. William C. Voorsanger, Mrs. E. S. Kilgore, and Mrs. Rea E. Ashley, directors.

There being no nominations from the floor, the report of the Nominating Committee was accepted in full, and a unanimous ballot was cast for the members' names so presented for office.

The Nominating Committee consisted of Mrs. Howard B. Dixon (chairman), Mrs. Philip H. Pierson, Mrs. Ernest C. Dickson, Mrs. John J. Sampson, and Mrs. A. G. Folte.

Honoring the sixty-two new members, from January 1 of this year, an informal reception followed the business period. Receiving with the president, Mrs. Hans Barkan, were the newly elected officers and directors for the ensuing year. Tea was served in the library, which commands a beautiful panorama of the Bay and the green-sloped hills beyond. Golden sunshine glimmered through the tall windows, seeming to welcome all to spring. A happy occasion to greet new members—new friends—interested in Auxiliary affairs; enthusiastic and eager to join us in our endeavor toward fulfilling the purposes of our organization.

Simplicity was the keynote of the decorations, with a soft pink predominating the color scheme. Mrs. Fred H. Zumwalt and Mrs. William C. Voorsanger presided at the tea table. Mrs. Edmund J. Morrissey, Membership Chairman, was in charge of arrangements, assisted by Mrs. William W. Newman.

The annual meeting is scheduled for Tuesday, April 19, at 1:30 p. m., 2180 Washington Street. The guest speaker of the afternoon will be Dr. J. C. Geiger, Public Health Officer for San Francisco.

Mrs. Harry R. Oliver, *Publicity Chairman.*

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San Joaquin County

The members of the Auxiliary to the San Joaquin County Medical Society held their last meeting at the home of Mrs. S. W. R. Langdon on the State Hospital grounds. The "Citadel," by Dr. A. J. Cronin, was reviewed. Mrs. G. K. Weaver presented Mrs. Robert Gordon, who sketched the story, an autobiography of a doctor who tried to live by professional ideals.

This group, which now meets monthly, entertained the state president, Mrs. Hobart Rogers of Oakland at the Christmas meeting in the home of Mrs. Dewey Powell. Mrs. Charles Hall, state corresponding secretary, was also a guest.

The San Joaquin County Welfare Department and its relation to other welfare agencies was explained in a talk by Ernest Stuart, county department head, who spoke at the February meeting of the Auxiliary. This meeting was held in the home of Mrs. C. D. Holliger, who was assisted by Mrs. P. R. Shumaker. Dainty refreshments were served at the conclusion.

Mrs. Paul Shumaker, *Chairman of Publicity.*

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Santa Barbara County

Santa Barbara held a business meeting on the morning of February 28 in the Board room of the Public Library. The object of this meeting was to make plans for March 14, when we are to have as our guests, Mrs. Hobart Rogers and Mrs. Charles C. Hall. This meeting will be in the form of a luncheon at the home of Mrs. Harry De Vigne. Dr. and Mrs. De Vigne occupy a well-known adobe home in Mission Canyon, and have furnished it with interesting and beautiful things collected during their many years of residence in Alaska. They have some fine old baskets and, among other things, two chairs which belonged to Diamond Lil of Sourdough fame. During many years of hospitality, Dr. and Mrs. De Vigne have acquired a reputation for pancake breakfasts which is enviable. In Mission Canyon, as in Alaska, these pancakes have been enjoyed by little-known travelers and noted people in all walks of life, who have only to pull the latch-string. In California they are cooked on the wide, flat top of a barbecue pit built close to the dining-room terrace, where they may be eaten inside in chilly weather, or outside under the shades of the oaks and ceanothus.

Mrs. H. E. Henderson, *Chairman of Publicity.*

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Tulare County

The Woman's Auxiliary to the Tulare County Medical Society was organized on January 27. The following officers were elected: Mrs. J. C. McClure, president; Mrs. F. R. Guido, first vice-president; Mrs. Forest Powell, second vice-president; Mrs. S. S. Ginsberg, recording secretary; Mrs. W. B. Parkinson, corresponding secretary; Mrs. P. S. Barber, treasurer; Mrs. P. D. Miller, auditor.

Mrs. J. C. McClure, *President.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of April is as follows:

Saturday, April 2—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 7,—KECA, 11:00 a. m., The Road to Health.
Saturday, April 9—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 14—KECA, 11:00 a. m., The Road to Health.
Saturday, April 16—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 21—KECA, 11:00 a.m., The Road to Health.
Saturday, April 23—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 28—KECA, 11:00 a. m., The Road to Health.
Saturday, April 30—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Group Hospitalization for Southern California.—The Associated Hospital Service of Southern California, which has been approved by the Los Angeles County Medical Association and the California Medical Association, is about to enroll subscribers. Mr. Harold B. Haas, of the Insurance Commissioner's office, at the banquet of the Association of Western Hospitals in San Francisco on March 2 announced that a permit would be issued. Twenty-eight hospitals in Southern California are now in the plan. It covers the territory from Santa Barbara to San Diego.

Who May Enroll

The Association plans to enroll employed groups and their families.

The individual rate will be 75 to 85 cents per month.

Husband and wife, $1.50 per month.

Family, regardless of the number of children under nineteen years of age, $2 per month.

Newspaper Comment

A great number of newspapers have given considerable space to the group hospitalization plan in Southern California. A recent editorial in the Los Angeles *Times* follows:

THE HOSPITAL GROUP PLAN

Announcement by a group of twenty-seven nonprofit Southern California hospitals of an insurance plan for hospital care is a big step forward. Fear of the cost of illness, one of the mental states which may be a contributing cause to illness itself, can now be removed by a plan within reach of the average family budget—ranging from three cents a day for an individual to seven cents a day for a family.

The plan appears to have all the advantages at which so-called "state medicine" aims, with none of the handicaps and disadvantages which state medicine and panel systems have been proved to have in practice.

The plan, which goes into effect on March 15, has been approved after careful study by the State Insurance Department, which considers it both sound and equitable. Features of all the various medical insurance plans in effect in this and other countries have been considered in drawing up the plan, and it is believed to be a combination of the best in all with avoidance of their serious defects.

It is designed to meet the hospitalization requirements of families with modest incomes, though wholly self-supporting—a group the needs of which have been largely neglected. There has been the best of hospital care available for those who do not have to count costs, and for the indigent, but those in between, the bulk of the population, have been little considered.

The plan is probably not perfect and will require adjustments as time goes on; but it is starting on a basis of solid experience elsewhere, and should develop into one of the most valuable contributions to popular well-being that has ever been made.

Stanford University "Popular Lectures."—The Stanford University School of Medicine announces the fifty-sixth course of Popular Medical Lectures (illustrated), to be given at Lane Hall on Friday evenings, April 1, April 22, May 6, and May 27, 1938, eight o'clock sharp.

The program follows:

Friday, April 1—Conditions of the Mouth in Relation to Disease," by Dr. Walter W. Boardman.

Friday, April 22—Backache: Causes and Treatments, by Dr. Donald E. King.

Friday, May 6—Forty, Fat, and Florid, and Heading for Circulatory Failure, by Dr. William J. Kerr.

Friday, May 27—Vitamin Facts and Fallacies, by Dr. Dwight L. Wilbur.

All interested are cordially invited to attend.

Association of Western Hospitals.—The Public Hospital Section of the convention of the Association of Western Hospitals and the Western Conference of the Catholic Hospital Association met in San Francisco, February 28 to March 4, inclusive.

The first session of the section convened on Tuesday, March 1, at 11 a. m. The postgraduate course for graduate and student nurses in psychiatric nursing was conducted by Dr. Margaret H. Smyth. Harry Lutgens, Director of the State Department of Institutions, was the discussant.

New legislation affecting institutions in this section were discussed by Dr. Leo W. Farrell, and Miss Mary Cronen gave a progress report on the study of hours of labor and wages of hospital employees of county hospitals.

On Wednesday, March 2, at the same hour, the second session opened with a discussion on the admission policies of state and county hospitals by A. M. Will. This was followed by a talk on "The Outlook of the Counties for the Disposition of Institutional Cases," by Dr. E. S. Loiseaux. "Alcoholic Colonies" was discussed by Dr. J. C. Geiger, and "Epileptic Colonies" by Dr. Thomas F. Joyce. Social security for county hospital employees was discussed by Dr. H. M. Ginsburg.

The cancer clinics were set for Thursday, March 3, with Dr. William B. Dorr, Superintendent of the Riverside County Hospital, Arlington, presiding. Talks were given on "Cancer Clinics," by Dr. Charles A. Dukes, Chairman of the Cancer Commission, California Medical Association; "Women's Place in Cancer Control," by Dr. J. M. Flude, western representative of the American Society for the Control of Cancer; "Cancer Control Today," by Dr. Alson Kilgore. A feature of this meeting was an address by Dr. Malcolm T. MacEachern, director of hospital activities for the American College of Surgeons, who spoke on the topic, "The Work of the American College of Surgeons."

*County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date, and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Krueger Is Given Grant by Medical Association.—Dr. Albert P. Krueger, Associate Professor of Bacteriology at the University of California, who recently announced that he had solved the mystery surrounding the identity of bacteriophage, has received a grant from the Committee on Scientific Research of the American Medical Association to aid him in continuing his work on the mysterious, bacteria-destroying protein.

Bacteriophage, one of the ranking enigmas of the medical world since its discovery by D'Herelle at the Pasteur Institute in 1917, thrives on a diet of bacteria. The name, "bacteriophage," given to the substance by D'Herelle when he found that it would destroy dysentery bacilli in the laboratory, means "bacteria-eater." Nevertheless, it has never been possible to use it as a cure for bacterial disease in human beings; this, despite the fact that in announcing his discovery D'Herelle predicted that bacteriophage would end all bacterial disease.

For many years bacteriophage was believed by most scientists, including D'Herelle, to be a mass of tiny parasites. However, Doctor Krueger, in experiments carried on at the University of California, proved conclusively that the mysterious bacteria-eater is really a solid, colorless germ-killing protein which thrives on a substance secreted by the bacteria. This evidence has now been accepted as definite proof by American scientists.

It is hoped that Krueger's discoveries concerning the identity and activity of bacteriophage, which is a simple virus, may lead to further discoveries concerning the more complex viruses which are believed to cause such diseases as infantile paralysis and encephalitis.

College of Medical Evangelists: Clinical Congress.—The Sixth Annual Clinical Congress of the College of Medical Evangelists, presented under the auspices of the Alumni Association, was held on Sunday, March 20, in Paulson Hall of the White Memorial Clinic, Los Angeles.

The program follows:

CLINICAL CONGRESS

Gadget, Hobby, and Art Display—Library
Pathological Museum—Basement Clinical Laboratory

Symposium at Paulson Hall

9:30 to 12:30

9:30—"Pre- and Postoperative Care of Heart, Nephritic, Hypertension and Diabetic Cases," Philip Corr, M.D.

9:50—"Prevention of Postoperative Pulmonary Complications," D. D. Comstock, M.D.

10:05—"The Choice of the Anesthesia," Charles F. McCuskey, M.D.

10:25—"The Treatment of Acute Cholecystitis," William H. Olds, M.D.

10:45—"Indications for the Use of Papaverin Hydrochlorid in Arterial Emboli," Donald C. Collins, M.D.

11:05—"Pre- and Postoperative Care of Thyroid Patients," Carl J. Baumgartner, M.D.

11:20—"Pre- and Postoperative Care of Fractures; Certain Helpful Suggestions in Prevention of Complications," H. Waldo Spiers, M.D.

11:35—"Complications that may develop in the Ear, Nose, and Throat following Surgery in that special field, and also those that may follow General Surgery," Benton N. Colver, M.D.

11:50—"Common Urological Complications following General Surgery; How to avoid them," Roger W. Barnes, M.D.

12:05—"Pre- and Postoperative Care in Anorectal Surgery," Malcolm R. Hill, M.D.

12:20—Welcome, Percy T. Magan, M.D.

12:30 to 1:30, Dinner

1:30 to 2:00, Medical Cadet Review—Tennis Courts

Clinical Demonstrations and Scientific Exhibits at the Dispensary

Continuously 2:00 to 4:30 p. m.

Cardiology

Roy Manning Clarke, M.D., and Donald E. Griggs, M.D., "Demonstration of Characteristic Lesions by Patients and Electrocardiographic Tracings."

Metabolic Diseases

Belle Wood-Comstock, M.D., "Demonstration by Patients and Charts of Weight Control."

Pediatrics

Albert L. Hill, M.D., "Differential Diagnosis of Mongolism, Cretinism, Achondroplastic Dwarf, and the Pituitary Dwarf," demonstrated with patients.

Neurological Surgery

Dorrell G. Dickerson, M.D., "Head Injuries, Brain Tumors, Spinal Cord Tumors," demonstrated by slides.

Diseases of the Chest

Marvin S. Harris, M.D.—"Bronchiectasis in Childhood," illustrated by x-rays.

Dermatology

Samuel Ayres, Jr., M.D., and Nelson P. Anderson, M.D., "Atypical Manifestations of Scabies," charts and photographs.

Paul D. Foster, M.D., "Allergic dermatoses," clinical and photographic demonstrations.

Allergy

Two-reel film, courtesy Mead Johnson Company, presented by Erving L. Rogers, M.D.

Roentgenology

Walter L. Stilson, M.D., "Typical Roentgenograms of Common Pathological Conditions."

Physical Therapy

Fred B. Moor, M.D., "Demonstration of Fever Therapy."

Orthopedic Surgery

Ernst Freund, M.D., "Surgical Treatment of Arthritis," patients showing end results.

David Kling, M.D., "The Practical Value of the Study of Synovial Membrane and the Synovial Fluid in Arthritis," illustrated by charts and slides.

Adolf Natzler, M.D., "Skeletons prepared after the Method of Virchow of Clubfeet, Flat Feet, Bunions, Hammer Toes, Plastic Amputations" (Stokes-Gritti, Pirigoff).

G. Mosser Taylor, M.D., "Manipulative Surgery," illustrated by motion pictures, charts, drawings, and demonstrations.

Ophthalmology

William A. Boyce, M.D., and Sidney Brownsberger, M.D., "Demonstration of Interesting Eye Cases."

Otolaryngology

H. James Hara, M.D., "Specimens of Foreign Bodies removed from Ear, Nose, and Lower Food and Air Passages."

Walter L. Stilson, M.D., "X-ray Films of Pathological Mastoids, Sinuses and Lungs."

Leland R. House, M.D., "Dissection of Head and Neck."

Merrill O. Dart, M.D., "Dissection of Temporal Bone."

Milo C. Schroeder, M.D., "Surgical Approach to Petrous Apex," demonstration by patients. Motion pictures: Instrumentation, Tonsillectomy, Mastoidectomy, Laryngo-Fissure, Tracheotomy, Peroral Endoscopy, Plastic on Rhinophynia, Surgery of Paranasal Sinuses.

Urology

Roger W. Barnes, M.D., Prostatic models, motion pictures, choice of: (1) Examination of Lower Urinary Tract (in sound and color); (2) Transurethral Prostatic Resection; (3) Suprapubic Enucleation of the Prostate; (4) Transperitoneal Nephrectomy; (5) Catheterization of the Urethra.

Proctology

Malcolm R. Hill, M.D., Roger W. Barnes, M.D., and Cyril B. Courville, M.D., "Vesical Dysfunction following Abdominal Perineal Resection for Carcinoma of the Rectum."

Malcolm R. Hill, M.D., motion pictures, choice of: (1) Examination and Diagnosis of the Anus, Rectum, and Sigmoid Colon (in sound); (2) One Stage Combined Abdominal Perineal Resection for Carcinoma of the Rectum (in color); (3) Rehabilitation of the Rectal Cancer Case (in color); (4) Vesical Dysfunction following Abdominal Perineal Resection for Carcinoma of the Rectum (lantern slides).

Obstetrics and Gynecology

Ralph Thompson, M.D., "Demonstration of Home Deliveries," motion picture; "Demonstration of Interesting Obstetrical and Gynecological Cases."

Medical Education

Walter E. Macpherson, M.D., Charts, Maps, and Statistical Information concerning Activities of the Medical School.

Visual Education

Herbert Childs, D.D.S., and Olov Blomquist, M.D.: (1) An Inexpensive Method of Producing Lantern Slides; (2) demonstration of these slides by projection on the screen.

Paulson Hall

4:30 to 6:30

4:30—"Diarrhea and Salt Metabolism," John E. Gregory, M.D.

4:50—"Surgical Treatment of Hypertension," Dorrell G. Dickerson, M.D.

5:10—Progress of the Association, Dee M. Rees, M.D., President.

5:20—Clinical Pathological Conference, Newton Evans, M.D.

6:10—News reels.

Registration fee $1.50. No registration fee will be required of students, interns or residents.

Brighter Children Tend to Grow Taller and Heavier. There is a slight tendency for brighter children to be taller and heavier than the average, according to intensive studies made over a period of several years by the Institute of Child Welfare of the University of California. The study was made on approximately two hundred Berkeley children by Dr. Marjorie Honzik, research associate, and Dr. Harold Ellis Jones, director of the Institute, and their findings included in the *Journal of Experimental Education.*

It was also noted that children who made above-average gains in mental growth, tended to show a more rapid course of physical development. There were many exceptions to this rule, however; enough to indicate that normal or above normal physical growth is not a necessary factor in normal mental growth. The children were tested and measured at regular intervals from twenty-one months to seven years of age. In one exceptional case a boy tested at two years was very markedly retarded in height, weight, and mental abilities. During the following five years he remained one of the smallest and lightest children in the group, but his mental gains were so rapid that by seven years he had achieved the mentality of a ten-year-old.

In concluding that physical and mental growth are associated, the investigators do not imply that an increase in rate of physical growth is a direct cause of an increase in rate of mental growth. It is more likely that they are both the result of underlying factors affecting in a number of ways the development of the individual.

University Enrollments in the United States: Fall Semester, 1937-1938.—The following figures have been compiled from the recent article in *School and Society,* by President Raymond Walters of the University of Cincinnati. The original statistics did not separate the University of California at Los Angeles from the total figures for the University of California.

California (Berkeley alone 14,694)	22,955
Columbia	14,683
Minnesota	13,691
Illinois	13,647
New York University	13,377
Ohio State	12,744
Michigan	10,952
Wisconsin	10,864
Washington (Seattle)	9,632
Texas	9,074
Harvard	8,138
C. C. of N. Y.	8,042
Louisiana State	7,644
U. C. L. A.	7,088
Pennsylvania	7,015
Hunter College	7,000
Nebraska	6,587
Cornell	6,439
Northwestern	6,221
Boston	6,217
Pittsburgh	6,172
Syracuse	6,077
Chicago	6,035
Purdue	5,907
Penn State	5,904
St. John's	5,888
Oklahoma	5,678
Missouri	5,589
Temple	5,464
Iowa State	5,423
Indiana	5,415
Yale	5,221
Iowa	5,145
Brooklyn	4,955
Michigan State	4,912
Alabama	4,907
Texas A. and M.	4,842
U. S. C.	4,707
Wayne	4,548
Kansas	4,383

WESTERN SCHOOLS NOT INCLUDED ABOVE

Arizona	2,224
California Tech	829
College of the Pacific	226
Loyola (Los Angeles)	585
Montana	1,951
Occidental	693
Oregon	3,103
Oregon State	4,013
Pomona	795
Redlands	561
Santa Clara	511
St. Mary's	498
Stanford	4,161
Washington State	3,807
Whittier	529

University of California: The Seventieth Charter Anniversary.—On March 21, 1868, the Legislature of the State of California gave its approval to a bill introduced by the Honorable John W. Dwinelle under the title, "An Act to Create and Organize the University of California." On March 23, 1868, this bill was made effective by the signature of Governor Henry H. Haight.

By this action the State of California laid down three fundamental principles which undoubtedly have had a favorable influence on its subsequent development. These principles were: that higher education should be available without tuition charge to all young men and women whose inherent endowments promised strength to the community; that whatever else might later be done to satisfy educational needs there should be a single state university as the culminating unit; and that the regents of the university should be left free to develop the institution in harmony with the needs of the people.

Under these principles, during the course of seventy years, the University of California has steadily broadened its service, has met the unique needs of the State by establishing additional campuses and research stations, and has attained a place of eminence among American universities. For these reasons the various divisions of the University, at Berkeley, Los Angeles, San Francisco, Davis, Mount Hamilton, Riverside, and La Jolla, joined in appropriate observance of the anniversary of the granting of the University Charter during Charter Week, March 19 to 26.

American Association for the Study of Goiter.—The American Association for the Study of Goiter, pursuant to its accepted invitation and to correspondence with the honorary presidents and attending members of the First and Second International Goiter Conferences, announces that the Third International Goiter Conference is to convene in the city of Washington, District of Columbia, September 12 to 14, 1938.

The subjects proposed for discussion are as indicated in the outlined tentative program.

Physicians and others in the United States and in other countries desirous of participating in the program are requested to submit titles at their earliest convenience. Since the time which it is possible to allocate on the program is obviously limited, it will be necessary for the Program Committee to exercise its best judgment in the selection of speakers and to insist, without exception, that the speakers conform to the time allocated.

Manuscripts of addresses, papers, and discussions delivered or read at the meetings are to be published *in extenso* in the form of transactions.

The official language of the Conference shall be English. Interpreters will be furnished for papers read in other languages.

For further information concerning the Conference, communicate with the officers of the American Association for the Study of Goiter or the chairman of the Program Committee.

OUTLINE OF TENTATIVE PROGRAM

First Day—Subject: Endemic Goiter, Cretinism, and Myxedema.

Etiology	Iodin
Pathology	Prophylaxis
Types	Thyroiditis
Geographic Distribution	Malignant Goiter

Second Day—Subject: The Thyroid in Relation to Metabolism, Nutrition and Endocrine Glands. Physiological and Pathological Interrelationship and Clinical Application.

Oxidation	Parathyroid
Sugar Metabolism	Pituitary
Water Balance	Adrenals

Third Day—Subject: Hyperthyroidism.

Basal Metabolism	Recurrences
Iodin	Goiter Heart
Complications	

Types: Diffuse toxic goiter; nodular toxic goiter.
Treatment: Nonsurgical; surgical.

The subdivisions under the subjects above are for illustrative purposes only and are not to be considered as all inclusive or exclusive.

California Academy of Sciences.—At an open meeting at the San Francisco Public Library on March 2, the California Academy of Sciences celebrated the centennary of the development of the cell theory by Schleiden and Schwann. Dr. Frank T. MacFarland, President of the Academy, surveyed the development of ideas relating to the cell theory and analyzed the significance of the contributions made by Matthias Schleiden (1804-1881) and Theodor Schwann (1810-1882).

Transatlantic Radio Conference on Rheumatic Heart Disease, May 2.—Leading British and American physicians, 6,000 miles apart, will confer via the radio on the greatest menace to child health, rheumatic heart disease. This conference, the first international broadcast on any health problem, will be heard over the National Broadcasting Company, WEAF and the Red Network, on Monday evening, May 2, at 7:30 o'clock, Eastern daylight saving time. Arranged by the American Heart Association, New York City, the conference-broadcast will observe National Child Health Day.

Lord Thomas Jeeves Horder, physician-in-ordinary to the King of England, will open the conference, speaking from London. Dr. Homer F. Swift of the Rockefeller Institute, New York City, and Dr. T. Duckett Jones of the House of the Good Samaritan, Boston, will then speak from Atlantic City, where they will be attending the convention of the American Society for Clinical Investigation. Dr. William J. Kerr, President of the American Heart Association, will take up the discussion from San Francisco.

Rheumatic heart disease is now recognized as the deadliest and most crippling affliction of children of school age. Its annual mortality rate is seven times that of dread infantile paralysis during an epidemic, while every year it invisibly cripples thousands more. Close to a million persons in the United States have hearts damaged by rheumatic fever.

Lord Horder's aerial report will dwell upon public health aspects of the disease, particularly in England. Doctor Kerr, from the West Coast, will tell of the work of the American Heart Association in this field. The radio audience will then be carried back to Atlantic City to hear Doctor Swifth describe the medical investigations being carried on to isolate the cause of the disease. Doctor Jones will follow with a discussion of the treatment of children with crippled hearts, emphasizing the need for long-continued sanatorial care.

This international conference-broadcast was conceived by a committee of Irvington House, sanatorium for the care of children with heart disease at Irvington-on-Hudson, New York, in an effort to stimulate greater public interest and action in this major child-health problem. It will acquaint doctors, and particularly parents and teachers, with the challenge of rheumatic heart disease, more dangerous because of the lack of knowledge of its nature and the difficulty in recognizing its early symptoms. Although no effective cure has yet been found, it is hoped that this broadcast will be a first step in the earlier recognition of the disease which, if unchecked, finally incapacitates the heart. A widespread realization of its prevalence should encourage increased support of scientific studies along these lines.

The present difficulty in arousing the attention of the public to rheumatic heart disease lies partly in its undramatic nature. Compared with the explosives and rapid pace of most childhood diseases, it plays the triumphant but unspectacular rôle of the tortoise in the fable of the tortoise and the hare. It is not easy, without specific education, to recognize the first slow manifestations of rheumatic heart disease as the onset of a systemic disease which may forever cripple the heart of a child.

On the Radio Committee of the American Heart Association responsible for arranging this conference-broadcast are: Doctors Arthur C. DeGraff (chairman), New York City; James G. Carr, Chicago; T. Duckett Jones, Boston; William J. Kerr, San Francisco; H. M. Marvin, New Haven; Edwin P. Maynard, Jr., Brooklyn; William D. Stroud, Philadelphia; also Miss Gertrude P. Wood of the American Heart Association and Mrs. Edwin H. Koehler of Irvington House.

American Board of Obstetrics and Gynecology: Examinations.—The oral, clinical, and pathological examinations for Group A and Group B applicants will be held in San Francisco on Monday and Tuesday, June 13 and 14, 1938.

An informal dinner for the diplomates of this Board, their wives and others interested in the work of the Board, will be held at the Palace Hotel on Wednesday evening, June 15, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, will address the group, and the successful candidates of the preceding two days' examinations will be introduced in person. Tickets, at $2.25 each, may be obtained in advance from Dr. Joseph L. Baer, 104 South Michigan Avenue, Chicago, Illinois, or at the door. Reservations should be made in advance if possible.

Application for admission to the June, 1938, Group A examinations must be on file in the secretary's office before April 1, 1938.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

American Urological Association: Western Branch. The Western Branch, Society of the American Urological Association meets at Los Angeles on May 12 to 14, 1938.

On Thursday evening, May 12, at the headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Dr. Thomas Addis of Stanford will deliver a lecture on the physiology of the kidney, describing the enormous advances accomplished by the leading research groups during the last decade. He will deal with the subject from a practical clinical standpoint, and this lecture should be of greatest practical value and interest to every practitioner, no matter what his line of practice. He will be followed by Doctor Drury, Professor of Physiology at the University of Southern California, on a somewhat different phase of the same problem.

On Friday evening, May 13, Dr. Fred C. Koch, Professor of Biochemistry at the University of Chicago and President of the "Association for the Study of Internal Secretions," and Professor James B. Hamilton of Yale will lecture on the male sex hormones and male sex hormone therapy—an up-to-the-minute symposium.

Members of the California Medical Association are cordially invited to attend not only the lectures above set forth, but any or all daytime sessions held on Thursday and on Friday at the Los Angeles County Medical headquarters.

Los Angeles County Quarantined for Rabies.—An investigation having been made as required in Chapter 369, Statutes of 1913, of the State of California, and rabies having been found to exist among dogs living within certain portions of the county of Los Angeles, the California State Board of Public Health, on February 17, 1938, in accordance with the provisions of Chapter 369, Statutes of 1913, declared a quarantine against all dogs and cats within all but the northern portion of the county of Los Angeles, exclusive of Los Angeles, Pasadena, Long Beach, Santa Catalina Island, Avalon, Beverly Hills, Vernon, South Pasadena, and San Fernando.

Quarantine under this Act means the strict confinement upon the private premises of the owners under restraint by leash or closed cage or paddock, of all dogs and cats within the above described area.

It shall be the duty of all peace officers, all deputies of the county health officer, as well as the county health officer, to enforce the provisions of this order within the above quarantined area.

The county health officer, or other properly constituted officials, may make inspection or examination and enter upon all private premises for the enforcement of this quarantine.

Any owner, or other person in possession of any animal being held or maintained in violation of this quarantine, shall be subject to arrest on the charge of committing a misdemeanor.

Tuberculosis Christmas Seal: 1937 Sale.—Comparative returns for the first forty-five days of 1936 and 1937, together with the total Seal sale for 1936, for the local Tuberculosis Associations from whom reports have been received both years are listed below:

	1936 Gross	1936 45 Days	1937 45 Days
Alameda	$31,953	$29,298	$29,791
Amador	847	807	935
Butte	1,292	551	869
Colusa	691	660	829
Contra Costa	4,122	3,740	6,825
El Dorado	1,014	940	880
Fresno	5,747	5,566	6,485
Glenn	336	300	357
Humboldt	2,100	2,000	2,026
Imperial	583	508	1,004
Kern	2,547	2,300	3,374
Lake	570	525	510
Lassen	747	715	763
Long Beach	9,841	9,528	10,502
Los Angeles City	55,076	50,121	65,967
Los Angeles County	26,439	24,715	27,111
Madera	929	829	1,014
Mendocino	1,390	1,207	1,306
Monterey	2,458	2,435	3,235
Napa	1,699	1,467	1,455
Orange	8,144	7,415	7,744
Pasadena	11,558	10,747	11,432
Placer	1,502	1,462	1,465
Riverside	4,349	4,086	4,226
Sacramento	9,051	7,846	10,184
San Benito	305	299	300
San Bernardino	3,769	3,673	4,020
San Diego	12,749	12,022	14,240
San Francisco	34,143	31,700	35,391
San Luis Obispo	1,612	1,568	1,389
San Mateo	6,423	6,000	7,665
Santa Barbara	4,679	4,569	5,020
Santa Clara	7,881	6,794	7,837
Santa Cruz	1,490	1,440	1,853
Siskiyou	462	459	1,431
Solano	2,881	2,579	3,320
Sonoma	2,222	2,177	2,291
South Pasadena	1,685	1,430	1,988
Stanislaus	1,429	1,429	2,466
Sutter	410	304	929
Yolo	1,114	1,102	2,022

University of California Medical School Offers a Short Course in Diseases of the Digestive Tract, April 13 to 16, 1938.—The course is designed to meet the needs of physicians engaged in general practice. Through clinical presentations, detailed outlines of treatment and demonstrations of actual diagnosis and therapeutic procedures, every effort will be made to make the course applicable to the problems encountered in practice. At the end of each lecture, there will be an opportunity to ask questions. The meetings will be held in Toland Hall, west end, first floor, University Hospital.

On Thursday and Friday mornings from 8 to 9 and on Saturday from 9 to 12, there will be demonstrations of operative treatment of the various organs of digestion. These will be held in the operating rooms, second floor, University Hospital.

Luncheon will be served on Wednesday, Thursday, and Friday, from 12 to 1, and dinner on Wednesday and Friday, from 5:30 to 6:30 in the Faculty Club, basement floor, University Hospital. During the luncheons, trays prepared by Miss Ann T. Lamb, Chief Dietitian, University Hospital, and the members of her staff, will be shown. These will illustrate the various diets mentioned in the lectures.

On Friday evening, following dinner, a round-table meeting will be held in Toland Hall, during which, through the method of question and answer and free discussion, some clinical problems will be presented. A box will be provided in Toland Hall so that those having questions for this meeting may leave them.

The tuition fee for the course will be $20. This will include the meals, mimeographed diet lists, and a syllabus. Registration will be held in the students' lobby, first floor, University Hospital (opposite Toland Hall), from 8 to 9:30 a. m. on Wednesday, April 13. Although there will be ample accommodations for all who wish to take the course, it is desirable to notify the Dean's Office, University of California Medical School, Medical Center, San Francisco, of your intention to register. This will facilitate arrangements.

California State Nurses' Association, District Five.—The Nursing Bureau Committee of this Association announces the following approved schedule of fees effective April 1, 1938:

General Nursing

In hospitals: $6 for eight hours. 75 cents for each additional hour.

In homes: $6 for eight hours. $8 for twelve hours.

It is understood that a nurse employed on a schedule in excess of eight hours will receive her meals, and that actual nursing service over a 24-hour period will not exceed twelve hours.

Extra Charges

One dollar additional will be charged for the care of the baby in obstetrical cases, and $2 for each additional patient in the hospital and at home. Maximum fee not to exceed $10 for eight hours.

Alcoholics

Eight dollars for eight hours. One dollar for each additional hour. Maximum fee not to exceed $12.

Note: Transportation to out-of-town cases, and cab fares for calls after 11 p. m. are the responsibility of the person calling the nurse. When order for a nurse is canceled after arrival on a case, the nurse is entitled to one-half day's fee.

Hourly Nursing

One dollar and twenty-five cents per hour for the first hour or fraction thereof. Fifty cents for each succeeding one-half hour, not to exceed three hours. Beyond a radius of five miles from the Los Angeles City Hall, mileage at five cents per mile will be charged.

Early Tests Tell Little of Later Intelligence.—Results of intelligence tests taken during the first three years of a child's life offer little indication of what his intelligence may be as an adult, according to Dr. Nancy Bayley Reid, research assistant at the Institute of Child Welfare of the University of California.

Her statement is based on a study carried out with thirty girls and thirty-one boys born in hospitals at Berkeley, first observations being taken within three days after birth. This study brought Doctor Reid one of the five awards of the American Educational Research Association for the most important contributions to educational research in the United States in the past three years.

On the basis of the results of her study, Doctor Reid believes, "the behavior growth of ten early months of infant development has little predictive relation to the later development of intelligence." As a general factor, she believes, intelligence cannot be measured until nerve and muscular coördinations are sufficiently mature to make possible those reactions which are characteristic of intelligence. Even then it may be possible to predict intelligence only within a given period of development which would still limit the value of mental tests on infants as an indication of their probable intelligence as adults.

Doctor Reid found one good argument for the theory of heredity when her tests showed that the most intelligent parents had the most intelligent children at the age of three years. Strangely enough, however, these children when they were less than seven months old showed lower intelligence than the sons and daughters of less intelligent parents. Doctor Reid believes this may be due to their more complex mentalities, which needed a longer initial period of development before they reached an efficient stage. Thus, the intelligence of the child's parents would seem to be a better indicator of future intelligence than his own early intelligence ratings.

Full-Time Health Units in California.*—*Alameda*—All unincorporated area and all incorporated cities except Alameda, Berkeley, Oakland, Albany, Hayward, Livermore, Emeryville, and Pleasanton; 52,797 out of 474,883 population.

Contra Costa—All unincorporated territory and all incorporated towns except Antioch, El Cerrito, Pittsburg, and Richmond; 41,472 out of 78,608 population.

* 1930 U. S. Census Bureau population data.

Fresno—All unincorporated territory and all incorporated cities except Firebaugh, San Joaquin, Clovis, Fresno, Fowler, Selma, Coalinga, Sanger, Reedley, Kingsburg, and Parlier; 73,370 out of 144,379 population.

Imperial—All unincorporated territory and all incorporated cities except Brawley, Calipatria, and Holtville; 47,152 out of 60,903 population.

Kern—All unincorporated territory and all incorporated cities except Bakersfield, Taft, and Mariposa; 52,042 out of 82,500 population.

Los Angeles—All unincorporated territory and all incorporated cities except Los Angeles, Long Beach, Pasadena, San Marino, Beverly Hills, South Pasadena, and Vernon; 716,168 out of 2,208,492.

Madera—All territory within the county; 17,164 population.

Monterey—All territory within the county; 53,705 population.

Orange—All territory within the county; 118,674 population.

Riverside—All unincorporated territory and all incorporated cities except Beaumont, Elsinore, Hemet, Blythe, Perris, Banning, San Jacinto, and Corona; 63,208 out of 81,024 population.

San Bernardino—All unincorporated territory and all incorporated cities except Chino, Colton, Needles, Ontario, and San Bernardino; 68,560 out of 133,900 population.

San Diego—All unincorporated territory and all incorporated cities except El Cajon, Escondido, Chula Vista, and Coronado; 195,894 out of 209,659 population.

San Joaquin—All territory within the county; 102,940 population.

San Luis Obispo—All territory within the county; 29,613 population.

San Mateo—All unincorporated territory and all incorporated cities except Burlingame, Daly City, San Bruno, South San Francisco, Belmont, San Carlos, San Mateo, Menlo Park, Redwood City, and Atherton; 17,487 out of 77,405 population.

Santa Barbara—All unincorporated territory and all incorporated cities except Santa Barbara; 31,554 out of 65,167 population.

Santa Cruz—All unincorporated territory within the county; 7,032 out of 37,433 population.

Stanislaus—All unincorporated territory and all incorporated cities except Newman, Patterson, and Turlock; 50,191 out of 56,641 population.

Ventura—All territory within the county; 54,976 population.

Yolo—All territory within the county; 23,644 population.

Cities—Berkeley, Oakland, Palo Alto, Pasadena, Long Beach, Los Angeles, Sacramento, San Francisco, San Jose, Santa Barbara, and Fresno; 2,707,911 population.

Total population served by full-time health units; 4,527,554 out of 5,677,250, or 79.7 per cent.

Press Clippings.—Some news items from the lay press follow:

Ten Million Yearly California Alien Relief

Sacramento, March 15.—(INS)—Aliens in California are receiving nearly ten million dollars yearly in direct relief, medical care and for the cost of confinement in institutions.

This was the claim made today in a legislative memorial that was en route to Congress and President Roosevelt seeking federal assistance in the continually growing problem.

Data gathered by Assemblyman James D. Garland of Woodlake presented to the Legislature showed 24.3 per cent of the resident population of state hospitals was made up of those who were not citizens of this country and that $1,044,267, or 18 per cent, was spent for their care during the past year.

It was also shown in Garland's report that there were 1,252 admitted aliens in San Quentin and Folsom prisons. Garland said there were probably more aliens, but they would not admit they were citizens of other countries.

Los Angeles County, Garland declared, has 7,500 Mexican aliens on various forms of public relief and which cost citizens $4,500,000 yearly. Orange County had 8,000.

Officials of several counties, including those of San Bernardino, Siskiyou, Marin and Mono, have urged federal legislation to meet the alien problem.—Los Angeles *Evening Herald-Express,* March 15, 1938.

Menace to Hospitals Described

Trends endangering the existence of private hospitals yesterday were revealed to the joint convention of the Association of Western Hospitals and the Western Conference of the Catholic Hospital Association.

Dr. Junius B. Harris, addressing the general assembly in the Fairmont Hotel, pointed to county hospitals as a danger factor. Said he:

"The greatest menace to private hospitals in California is the trend towards opening county hospitals to all patients regardless of their ability to pay. This is the avenue through which state medicine will come if it comes."

He also viewed with alarm the trend towards allowing those without medical licenses to practice in certain county hospitals.

Earlier, the convention had discussed its most serious research problem: Cancer. Dr. Alson R. Kilgore pointed out that, treated in early stages, some types of cancer are being permanently cured in 80 per cent of all cases.

Dr. Z. E. Bolin added that the family doctor was the key man in early treatment.

"Therefore," he recommended, "it is advisable for all hospitals who find it possible to form cancer clinics which the family doctor may attend."—San Francisco *Examiner,* March 4, 1938.

* * *

New Hospital Charges

New charges against the Los Angeles County General Hospital and its administration were contained today in a second editorial by Dr. George H. Kress, president of the County Medical Association, appearing in the current issue of CALIFORNIA AND WESTERN MEDICINE, official organ of the State Medical Association, of which Doctor Kress is editor.

In his latest editorial, Doctor Kress renews previously aired allegations that payment of bills is pressed against indigent patients and that charges in the General Hospital are higher than at outside hospitals. Doctor Kress asserts that "hospital authorities, through the collection bureau of the Charities Department, are using methods so seemingly harsh that the indigent poor and their friends, about 500,000 persons, are driven to become in many instances more or less antigovernmental and bolshevistic."

Doctor Kress attached to his latest editorial numerous letters from other physicians and former General Hospital patients to support his claims, and quotes at length the results of an investigation already undertaken by order of the county supervisors into his originally printed charges.—Los Angeles *Evening Herald-Express,* March 9, 1938.

* * *

New Hospital Plan Adopted

State Permit Paves Way for Group Care Through Insurance

A group of twenty-seven leading hospitals of Southern California will inaugurate group hospitalization on March 15 as a result of the granting late yesterday by the State Insurance Commission of the first permit to be issued under Assembly Bill 1132, which makes it possible for individuals and families to pay their hospital bills like insurance, at a rate of a few cents a day.

The permit was presented last night at the closing meeting of the Western Hospital Association, in San Francisco, to Ritz E. Heerman, superintendent of the California Hospital and prime mover in the drive to obtain such legislation for California.

A nonprofit organization known as the Associated Hospital Service of Southern California has been formed among leading hospitals of the Southland, according to Dr. L. B. Rogers, exeeutive director of the group, which has opened offices in the Chamber of Commerce Building.

The group is headed by Mr. Heerman as president; Dr. William H. Kiger, vice-president; Leonard K. Brown, secretary; Dr. Edw. M. Pallette, treasurer, and Rt. Rev. Msgr. T. J. O'Dwyer, Dr. Glen E. Myers, Dr. Philip J. Edson, Dr. J. M. Burlew, Roland Maxwell, Anna K. Volger and G. Henniger, R.N., as directors.

Hospitals in the group are Alhambra, California, Cedars of Lebanon, Centinela, Collis P. and Howard Huntington Memorial, Foster Memorial, Good Samaritan, Jared Sidney Torrance Memorial, Las Campanas, Loma Linda, Long Beach Community, Mercy, Methodist, Mission, Physicians and Surgeons, Presbyterian-Olmsted Memorial (Hollywood), Riverside Community, San Pedro General, Santa Barbara Cottage, Santa Fe, Santa Monica, Scripps Memorial, Seaside Hospital, St. John's, St. Joseph's, St. Luke's and White Memorial.

Budgeting Planned

Group budgeting plans for hospitalization have been developed in fifty communities in the United States and have a total membership of over one million subscribers, according to President Heerman of the new California group. All these plans have been carefully studied and the enabling legislation for California drawn with the utmost public protection in mind.

No hospital is admitted to the group which does not hold a certificate from the California Board of Public Health, and groups formed under this law must be nonprofit and must have a permit from the Insurance Commissioner.

Designed as a service to persons of moderate means, the plan permits enrollment of employed groups of five or more at rates ranging from 3 cents a day for individuals to 7 cents a day for an entire family, regardless of size.

No physical examination is required, and service will include all items usually furnished in a hospital with the exception of fees of the medical practitioner. The subscriber will have free selection of physician and hospital, but he must pay for the physician. The plan covers all illnesses or accidents except those covered by compensation laws or diseases which are quarantinable or subject to isolation by the Board of Health.—Los Angeles *Times*.

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Group Hospital Move Praised

Head of Association Says 1,500,000 Get Care at Low Cost

"Group hospitalization is spreading over the country and will be a bulwark against state medicine," Robert E. Neff, president of the American Hospital Association, said yesterday at the Biltmore.

Nominal Fees

By the plan, already established in seventy cities, the hospitals join in offering services for nominal fees paid like insurance. New York has a 3-cents-a-day plan that has worked out well, Neff says. Altogether in the country there are 1,500,000 persons protected by the group hospitalization.

"It is a boon to the wage-earning class," Neff says, "and by offering it protection at low cost removes one of the chief arguments for government medicine."

Plans Session

Neff is administrator of the State University of Iowa Hospitals, with headquarters at Iowa City. He comes from Dallas, where he made preliminary arrangements for the convention of the American Hospital Association to be held there in September. He is on his way to San Francisco to attend the Association of Western Hospitals convention there next week.—Los Angeles *Times*.

* * *

White House Given Measure to Curb Injurious Advertisements

Washington, March 14.—(AP)—Legislation increasing powers of the Federal Trade Commission over advertising of food, drugs and cosmetics won approval of the Senate today and went to the White House.

Senator Wheeler, Democrat, of Montana, said "this is one of the greatest steps toward the elimination of unfair practices that has ever been taken by Congress."

The Montanan said that previously the federal agency could act only when firms injured competitors, whereas the new bill covers injury to the public.

Senator Copeland, Democrat, of New York, criticized the measure as not broad enough. Consumers will suffer, Copeland said, because the bill stresses four articles—food, drugs, cosmetics and devices—instead of any commodity.

Wheeler insisted Copeland was misinformed. Any person who is injured by a product can demand action by the commission or the agency can act upon its own initiative, he said.

The commission can obtain an injunction to halt distribution of any injurious product, he added. Violations could mean penalties up to $5,000.—Los Angeles *Times*, March 15, 1938.

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New York Passes Social Disease Test Law

Albany, March 9.—(INS)—By overwhelming vote, the New York State Assembly today passed a bill requiring that expectant mothers undergo medical tests for social disease. The vote was 116 to 4.—Los Angeles *Examiner*, March 10, 1938.

* * *

County-Wide Control of Tuberculosis Recommended

A survey of the tuberculosis control program in Los Angeles County, prepared by Dr. Robert E. Plunkett, general superintendent of tuberculosis hospitals of the New York State Department of Health, for the Department of Budget and Research of Los Angeles County, was submitted by the director of the department to the County Board of Supervisors on December 8.

The report of the survey, which was conducted under the auspices of the U. S. Public Health Service and the State Department of Public Health, has recently been made public, and mimeographed copies distributed.

A summary of recommendations states:

"In this survey of the administrative tuberculosis control program in Los Angeles County, the health of the community and the financial interests of the citizens have been the determining factors in the following recommendations:

"1. Organization of a county-wide department of health under a commissioner of health.

"2. Appointment of a director or comptroller of tuberculosis in the County Health Department.

"3. Clinicians in charge of existing health centers to serve under the supervision of the director of tuberculosis in the administration of the local tuberculosis programs.

Additional Beds Needed

"4. Construction of two new tuberculosis hospitals of 500-bed capacity each.

"5. The superintendent of each tuberculosis hospital (new and old) to function under the general supervision of the director of tuberculosis.

"6. The Health Department to be responsible for the ultimate decision as to the eligibility for hospital care in all cases on the basis of the best health interests of the public and the individual, without regard to the patient's ability to pay.

"7. Quantitative clinic services to be provided on the basis of district mortality and morbidity. All tuberculosis clinics to be operated by the medical staffs of the hospitals in the respective hospital districts. Tuberculosis clinics to be regarded as educational centers to which local physicians should be encouraged to come for instruction in diagnostic methods.

"8. Organization of a unified field nursing program under the director of public health nursing in the department of health, coöperating with director of tuberculosis.

"9. The development of an adequate medical social program."—*News Letter*, California Tuberculosis Association.

* * *

Single Health Unit Urged for County

Organization of a county-wide public health department to include the Los Angeles metropolitan area yesterday was recommended to the county government by Dr. F. M. Pottenger, head of the county's tuberculosis advisory board. At present the Los Angeles City Health Department is separate and independent of the County Health Department.—Los Angeles *Times*, March 3, 1938.

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Supervisors Order Survey for Revision of Charter

Studies with a view of revamping the charter of Los Angeles County, effective since June 2, 1913, were ordered by the Board of Supervisors on motion of Supervisor McDonough.

Under the resolution a committee comprised of the County Counsel, County Auditor and director of the county Bureau of Budget and Research will be formed to start the survey looking toward revisions in the charter that could be placed before the voters in the coming November election.

Ask Recommendations

Each county governmental department head is instructed to make a study of his department to formulate recommendations to be submitted to the committee by May 1. The committee itself will make its report to the Board of Supervisors not later than August 1.

The action of the county officials is coincident with those in the city of Los Angeles who are making a study of the city charter with a view of revamping that document.

Approved in 1913

The county charter was approved by the State Legislature on January 29, 1913, and became effective June 2 that same year.

A special committee is now making a study of county civil service regulations. The findings will be laid before the charter committee, Supervisor McDonough said.—Los Angeles *Times*.

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Medical Care Plan Outlined

Group Insurance Praised in Address to Hospital Leaders

San Francisco, March 1.—(AP)—Group insurance, "which helps the patient to help himself," was pictured to several hundred western physicians and hospital directors today as "a great bulwark against government medicine," in an address by Robert E. Neff of Iowa City, Iowa, president of the American Hospital Association.

Neff told the Association of Western Hospitals and the Western Conference Catholic Hospital Association that "it should be remembered there is no such thing as free hospital care—somebody has to pay. And with the public becoming more and more insistent that all persons have hospital care, that demand must be met in some way."—Los Angeles *Times*.

Los Angeles County Has 47,281 Old-Age Pensioners; Total Growing

Old-age pensioners are increasing rapidly in Los Angeles County.

By next June there will be approximately 62,300 old-age pensioners, blind and child-aid cases, as compared with 54,799 in November, 1937, and 35,481 in July, 1936, according to a report filed with the Board of Supervisors today by Rex Thomson, county superintendent of charities.

During the current fiscal year approximately $21,000,000 will be spent in this county on such cases, according to Thomson. Of this amount $7,119,587, or 34.1 per cent, will come from county tax funds. This amount will include the administrative costs, and comes almost entirely from county funds.

A breakdown of the types of assistance given shows 29,580 old-age pension cases in July, 1936, as against 47,281 today. Needy blind cases totaled 2,634 in July, 1936, and 2,800 today. Dependent children cases increased from 3,267 in July, 1936, to 4,574 at the present time.

Allowances for old-age pension cases in July, 1936, totaled $621,015, against $1,193,391 in November, 1937. Blind aid allowances were $84,926 in July, 1936, and $125,114 last November. Child aid costs were $88,840 in July, 1936, and $143,698 in November last. The cost of these cases, all of which are mandatory on the county by state law, is borne by the county, state and federal governments. —Los Angeles *Evening Herald-Express.*

* * *

Old-Age Pensions Paid 100,000 Californians

Sacramento, Feb. 28.—(Exclusive)—More than 100,000 elderly persons in California received old-age pension payments in January, Mrs. Florence L. Turner, State Director of Social Welfare, announced today.

A total pension payment of $3,326,191 was made to 100,834 persons for an average of $32.99 per case, Mrs. Turner said.

In Los Angeles, 37,258 persons received the pension, with the amount expended being $1,241,557. The average per case was $33.32.—Los Angeles *Times.*

* * *

Doctor Gives Life in Jungle Search for Paul Redfern

Georgetown (British Guiana), Feb. 17.—(AP)—The Colonial Secretary's office today announced that Dr. Frederick J. Fox of Boston, member of the Waldeck Expedition, had died on Devil's Hole Island, deep in the jungle, where the expedition had been marooned.

Word of the death was brought out of the jungle by James De Souza, leader of a party which had gone to the aid of the expedition. He said Doctor Fox already had been buried when the relief party reached the island. His message did not give details of Doctor Fox's death.

De Souza, returning to Bartica, reported the expedition, released from the island on which it had been trapped by high water and defection of its native bearers, had continued farther into the interior.

The expedition, under Theodore J. Waldeck, American explorer, has been searching for Paul Redfern, long missing American aviator.—Los Angeles *Times.*

* * *

Insulin Aids 100 Undernourished

Boston, March 5.—(AP)—The New England *Journal of Medicine* today reported 100 thin men and women, suffering from malnutrition, showed striking improvement through the use of insulin, gaining immediately in weight and appetite.

Most of the 100 persons studied "noted an improved general and mental condition, an increase in strength and efficiency, and better intestinal functioning," the report said.—San Francisco *Examiner,* March 6, 1938.

* * *

Plan for Cure of Alcoholics

Suggests Fund Be Provided from Liquor Tax Revenues; Proposes Two Institutions

Plans which may be the basis of a workable project for the solution of a growing problem—what to do about habitual drunkards—were presented in detail here last week before the meeting of the Association of Western Hospitals.

Author of the plans is Dr. J. C. Geiger, director of public health. Fundamental principle involved is this—"costs of care and treatment for drunkards should come from liquor taxes."

Major Social Problem

"Chronic alcoholism has become a major social problem," Doctor Geiger said. "Its victims require medical care in most cases and should be sent to special work farms where such care may be provided.

"Hopeful patients should not be treated in the same institutions with psychopathic and degenerate drunkards. This last group," Doctor Geiger explained, "are only secondarily alcoholic. Their alcoholism is merely one of the symptoms of a deeper and more fundamental disorder and they not only fail to be cured, but actually hinder the cure of more promising patients."

Two Institutions

Careful selection of cases for treatment, ample time periods for its accomplishment should be allowed, he said. Two special institutions, one in northern, one in southern California, could readily be established.

He quoted state financial reports which show that, in 1937, excise taxes on beverages totaled $1,889,079; license fees, $5,699,354; distilled spirits excise stamp tax sales, $8,248,599; fines, $85,871, and the sales tax intake, "another tremendous sum."—San Francisco *Examiner,* March 6, 1938.

* * *

$30,000 for Cancer Relief

As the result of the grant of $30,000 by the National Advisory Cancer Council of Washington to the University of California, great progress will be made in the treatment of cancer by radium and radio-active substances, it is believed here.

The money will be spent entirely in the laboratory of Dr. E. O. Lawrence, professor of physics and head of the university's radiation laboratory.

The grant came as the result of the latest achievements of Doctor Lawrence's cyclotron in the development of synthetic radium and radioactive substances.

In this cyclotron various substances are bombarded with electrical rays until their atoms are broken down and they form new substances. One of the latest of these experiments was the formation of synthetic radium.

With the $30,000 grant, a new and much larger laboratory will be built and a much larger cyclotron, to be known as a "medical cyclotron," will be installed for the production of purely radioactive substances for medical use and specially for the treatment of cancer.

To date, the old cyclotron has produced more than 200 radioactive substances, such as radiosodium, radiophosphorous and radioiron.

The present limited laboratory has produced these substances equal in radioactivity to one gram of radium. These amounts have been found adequate for hospital experimental use and at present can be produced at a cost comparable with that of radium.

However, as the cyclotron is only in the early stages of its technical development, Doctor Lawrence is convinced that its efficiency can be improved and that it can be made to produce the equivalent of ten grams or more of radium.

Great Expansion Seen

This would permit the most extensive use of radium and open up vast fields of experimentation with it in various diseases. It was for this purpose that the $30,000 grant was made.

One of the most important features of the newly created radioactive substances by the cyclotron is that they are not toxic. They can be taken into the digestive tract or administered intravenously without harmful consequences.

These substances also permit a close observation of their action on the blood and the body of the patient by the "tagging" of atomic content through radioactive properties. —San Mateo *Times,* March 14, 1938.

* * *

Expansion of Health Units in San Francisco

Rossi Given Proposal for Widening Activities in San Francisco at Cost of $86,000 a Year

A major expansion of the Health Department's activities, which would cost approximately $86,000 per year, was proposed to Mayor Rossi yesterday by Dr. J. C. Geiger, health director.

Suggested was establishment of a bureau of tuberculosis, concentration of efforts to combat the social disease plague under one executive, with establishment of new clinics, and increase of the present $20,000 fund supplying free milk to indigent and undernourished children to $30,000.

Increase Sought

Doctor Geiger also pointed out that the department's bureau of sanitary engineering was only a "skeleton" organization, and that the personnel should be increased.

Transfer of the bureau of plumbing from the Department of Public Health to the Department of Public Works was suggested. All city inspection services should be coordinated under a technically qualified director, Doctor Geiger declared.

"There should be established two additional infant welfare stations in strategic positions in the city where subnormal living conditions are present," the health director informed the mayor.

Hospital Proposed

Establishment of a new unit of the Emergency Hospital, at a site to be selected, also was proposed, as well as reorganization of the Health Department's building arrangements.

The improvement program was formulated with aid of University of California public health professors.—San Francisco *Examiner*, March 2, 1938.

* * *

Rabies in California

During the past fifteen years, 1922 to 1937, 12,926 cases of rabies in animals have been reported to the California State Department of Public Health. Their distribution, by animals, is as follows:

Dogs	12,105	Mules	10
Cats	256	Foxes	2
Cows	319	Monkeys	2
Horses	30	Rat	1
Coyotes	25	Squirrel	1
Goats	43	Raccoons	2
Hogs	12	Rabbits	2
Sheep	92	Unknown	19
Skunks	5		
			12,926

The distribution of these 12,926 cases of rabies in animals, by counties, is as follows:

Alameda	125	Plumas	38
Amador	2	Riverside	108
Butte	1	Sacramento	83
Calaveras	3	San Benito	24
Contra Costa	37	San Bernardino	277
El Dorado	6	San Diego	643
Fresno	226	San Francisco	5
Humboldt	11	San Joaquin	253
Imperial	244	San Luis Obispo	10
Inyo	6	San Mateo	11
Kern	92	Santa Barbara	20
Kings	101	Santa Clara	40
Lake	1	Santa Cruz	20
Lassen	30	Shasta	7
Los Angeles	9,377	Siskiyou	14
Madera	84	Solano	2
Marin	76	Sonoma	12
Mariposa	1	Stanislaus	193
Merced	54	Tehama	1
Modoc	95	Tulare	150
Mono	1	Tuolumne	2
Monterey	124	Ventura	35
Napa	7	Yolo	14
Nevada	7	Yuba	5
Orange	234	California *	2
Placer	12		
			12,926

* Dog brought into California from Denver, Colorado. Raccoon brought to Imperial County from Mexicali.

NOTE.—Only those counties that have reported cases are listed.

Human Cases

Since 1899, when rabies first appeared in California, eighty-six human beings have died of this disease. Of these, thirty had received the Pasteur treatment for the prevention of rabies. It must be remembered that this is a fatal disease, and that no one who has once shown symptoms of rabies has ever recovered. It is 100 per cent fatal.

The Pasteur treatment, in order to be effective, depends upon several factors, such as prompt administration following bite of an infected animal and location of bite, those near the larger nerve centers being much more serious. Cauterization of the wound with fuming nitric acid, which is the only reliable cauterizing agent, is also of prime importance n preventing the development of rabies.

Of the thirty fatal cases in which the Pasteur treatment was given, thirteen had received no cautery. In nine cases wounds were cauterized with nitric acid, four with iodine, two with carbolic acid, one with argyrol and one with silver nitrate. The records show that in only nine out of thirty cases were wounds cauterized with nitric acid. Of the remaining fifty-six cases out of the total that have occurred since 1899, only five had received cauterization with nitric acid.

Since the location of the wound is of great importance in rabies, it is interesting to note that in these thirty decedents, sixteen had been bitten on the head and face, seven on the hands, one on the wrist and face, two on the arm or wrist, one on the legs, one on the foot and wrist and in two cases the location of the bite was not recorded.

In three cases treatment was started the same day that the patient was bitten and in ten cases treatment was started five or more days after having been bitten.

Regardless of the location of the wound, 76 per cent of these cases, for which the incubation period is known, had incubation periods of sixty days or less. In no case was the incubation period less than ten days. In only three cases did it extend over a period longer than six months.

While the Pasteur treatment is ineffective in a small proportion of cases, particularly those involving severe bites about the head, face and arms, it is generally effective, and under improved methods of administration far better results are obtained now than were possible when the method was in its infancy. In the Pasteur L'Institut, Paris, where more than 500 patients receive the treatment each year, a fatality seldom occurs. In those cases where the lacerations occur on the head and face the infection sometimes develops more rapidly than immunity can develop through the Pasteur treatment.—*Weekly Bulletin, California Department of Public Health*, March 5, 1938.

* * *

Dog Bite Victim Dying, Report of Health Officer

Bitten by a cocker spaniel dog a month ago, according to health authorities, Rufus Bradley, 141 North Grand Avenue, was reported dying at General Hospital today from rabies, according to Dr. George Parrish, city health officer.

Bradley was one of nine persons the dog reportedly attacked when he ran from his home in Glendale to downtown Los Angeles.

Seven of the nine reported to the Health Department for Pasteur treatments, Parrish said, and they are now recovering. Stephen Wilson, who failed to take the Pasteur treatments, died several days ago. Bradley also had failed to take Pasteur treatments.—Los Angeles *Herald-Express*, March 24, 1938.

LETTERS

Concerning the Los Angeles County Hospital.

AMERICAN COLLEGE OF SURGEONS

Chicago, March 16, 1938.

To the Editor:—I wanted to see you while in Los Angeles several days ago, but my time was taken up with two or three meetings which I had to attend and, therefore, did not have an opportunity to discuss with you the Los Angeles County Hospital situation. . . .

Since receiving the Los Angeles County Hospital material you sent to me, I have reviewed it very carefully, and I am convinced that you worked up an excellent case which will surely have effect in changing the unfortunate policy which the Board of Supervisors have adopted in connection with the County Hospital.

I hope the time is not too far distant when the plan and set-up followed in Alameda County will be adopted in Los Angeles County. There is no question whatsoever but that the Alameda County plan is the best one under which any county hospital can be run. . . .

The county hospitals certainly should be kept exclusively for indigent cases and not for patients who are able to pay their way. . . . It is highly unfair to the taxpayer and to the physician to open the county hospitals to all people, regardless of their financial status, and I am sure that you will get lots of support in the investigation of the situation which you are now endeavoring to expose. Your premises are exceedingly well taken.

Rest assured of my deep interest in this matter and desire to give you any personal support I can in the issues mentioned in your letter and the material which you so kindly sent me.

Very sincerely yours,

MALCOLM T. MACEACHERN, M.D.,
Associate Director.

Concerning rabies quarantine in Ventura County.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

Modification of order issued December 8, 1937, declaring a quarantine against all dogs and cats within the boundaries of the county of Ventura.

To the Editor:—Having received from Charles R. Wylie, M.D., Health Officer of Ventura County, a request for the modification of the order issued December 8, 1937, declaring a quarantine against all dogs and cats within the boundaries of the county of Ventura, the California State Board of Public Health having made an investigation in accordance with the provisions of Section 2, Chapter 369, Statutes

of 1913, hereby modifies the above-mentioned quarantine order as follows:

Quarantine shall be defined as the confinement of all dogs and cats within the designated area upon the private premises of the owners under restraint by leash or closed cage or paddock, except that persons over the age of fifteen years shall be permitted to take their dogs and/or cats on the public streets and highways when such animals are controlled by suitable leash not over five feet in length, and when so controlled may also take them on the highway in automobiles; *except* that those dogs and cats, quarantined as rabies contacts and confined to their premises or such other place as may be designated by the health officer or his representative, shall not be permitted to leave the designated premises upon which they are confined.

March 2, 1938.

W. M. Dickie, M.D.,
Director of Public Health and Executive Secretary, State Board of Public Health.

Concerning Portland meeting of American Public Health Association: Western Branch.

To the Editor:—May we ask you to call the attention of your readers to the fact that the Western Branch, American Public Health Association, will hold its ninth annual meeting in Portland, Oregon, June 6, 7, and 8, 1938. The program will be devoted to discussion of public health matters of special interest to the West, and will present speakers of national and western prominence.

Inquiries should be addressed to Dr. William Levin, State Department of Health, 816 Oregon Building, Portland, or to the undersigned.

Sincerely yours,
W. P. Shepard, M.D.,
Secretary.

Concerning Child Health Day, Sunday, May 1, 1938.

U. S. Department of Labor
Children's Bureau
Washington

To the Editor:—Dr. W. W. Bauer, Director, Bureau of Health and Public Instruction of the American Medical Association, has suggested that we send to you the enclosed Suggestions for the Observance of May Day—Child Health Day, 1938—with the request that you give some notice to it in your state medical journal. . . .

Sincerely yours,
Katharine F. Lenroot,
Chief, Children's Bureau.

* * *

(copy)

May Day—Child Health Day, 1938
Sunday, May 1
Supplementary Observance, April 30 and May 2

Suggestions for Observance

Child Health Day activities are sponsored by the Children's Bureau at the request of the State and Provincial Health Authorities of North America in accordance with the Congressional Resolution of May 18, 1928, which authorized the President to proclaim May Day as Child Health Day.

Slogan.—Speed children on the road to health.

Objective.—Every community to make full use of its resources in order to insure to children safe birth, normal growth, and protection against disease and accident in their progress from infancy to maturity.

Leadership.—State May Day chairmen appointed by State health officers arrange for the coöperation of State and local public agencies and private organizations in planning May Day activities that will contribute to year-round child-health activities. State departments of education cooperate in planning school Child Health Day programs.

Program.—For community groups: (1) Review of local child-health activities; (2) planning for the extension and improvement of child-health programs; and (3) presentation of special child-health needs requiring the attention of parents and others in the community.

By children: Exhibits, demonstrations, programs, plays, games, and festivals, illustrating the health needs of children, healthful activities, and progress made during the year in their knowledge concerning the protection of their own health and of the health of the community.

For the general public: News stories, radio talks, speeches, posters, exhibits.

For information on State programs, write to State May Day Chairman, State Department of Health.

Committee of Revision
of the
Pharmacopoeia of the United States of America
1930–1940

Announcement by the U. S. P. Anti-Anemia Products Advisory Board Concerning Liver Preparations Conforming to U. S. P. Standards

To the Editor:—When liver and stomach preparations were admitted to the U. S. Pharmacopœia, Eleventh Edition, it was recognized that these products presented a different problem, from the viewpoint of standardization, than any question previously before the Pharmacopœia.

As no ordinary methods for standardization or testing were available, an Advisory Board, made up of specialists in the treatment of anemia, was appointed. This Board established methods for determining the value of anti-anemia products, and the basis for a U. S. P. "unit of potency." They also issued forms for reporting evidence of clinical value and announced regulations for indicating the potency of U. S. P. products and for the wording of the labels.

On the invitation of the Board, a large number of clinical reports were submitted by manufacturers in evidence of the value of their products, and the Anti-Anemia Board, after reviewing these records, herewith submit their conclusions. This first report lists the products which have been approved up to this time as complying with the U. S. P. specifications and the firms authorized to sell or distribute them.

As is probably generally known, only a relatively small group of manufacturers have provided the necessary hospital facilities for checking the clinical value of anti-anemia products as required by the Board, and several of these distribute their products through the medium of other pharmaceutical firms.

Having been supplied with adequate clinical evidence of the efficiency of a manufacturer's product and having accepted it as of U. S. P. grade with a specific dose, the Anti-Anemia Board, on request, have also authorized the distribution of some of these approved products by other firms when the firms have given assurance that their handling of the products will in no way alter its quality or potency. No doubt the Board will later report additional approved preparations and firms.

Any assistance which you can give in extending publicity to this report will be appreciated.

Forty-third Street and Woodland Avenue,
Philadelphia, Pa.

Respectfully,
E. Fullerton Cook.

Concerning rehabilitation of mental defectives.

To the Editor:—Dr. Walter E. Fernald, one of the greatest pioneers in the treatment of the mentally deficient, once said:

"There is no panacea for feeble-mindedness. There will always be mentally defective persons in the population of every state and country. All of our experience in dealing with the feeble-minded indicates that if we are adequately to manage the individual defective, we must recognize his condition while he is a child, protect him from evil influences, train and educate him according to his capacity, make him industrially efficient, teach him to acquire correct

habits of living, and, when he has reached adult life, continue to give him the friendly help and guidance he needs."

How New York State is providing for the rehabilitation of its mental defectives who are capable of material improvement, and for the humane custodial care for persons of such a low grade of development that they cannot be restored to community life, are discussed in a newly published report of the survey of the methods of care, treatment, and training of the feeble-minded at Letchworth Village, Thiells Post Office, Rockland County, New York, one of the state's largest institutions for the mentally deficient. Upon request, we will be glad to send you a copy of the report.

Sincerely, yours,
F. B. Kirkbride,
President.

Concerning Coöperation of Major Disaster Emergency Council in recent Los Angeles floods.

Major Disaster Emergency Council
2224 West Sixth Street (Westlake Park)
Los Angeles California

March 22, 1938.

To Medical and Sanitation Committee:
George Parrish, M.D.
Edward M. Pallette, M.D.
George H. Kress, M.D.

Dear Doctors:—You will find enclosed a facsimile of a letter from the Mayor. This letter carried his appreciation to all members of the Emergency Council. Therefore, I felt I should pass it on to you.

You will also find enclosed a copy of my report on the activities of the Emergency Council.

Respectfully,
Basil E. Rice,
Director of Coördination.

* * *

(copy)
Office of the Mayor
City Hall
Los Angeles, California

March 11, 1938.

Mr. Basil E. Rice
Director of Coördination
Major Disaster Emergency Council
2224 West Sixth Street
Los Angeles, California

Dear Mr. Rice:

I feel that you and your associates in the administration of the Major Disaster Emergency Council are deserving of the highest commendation for the effective manner in which you responded to your first alarm on March 2, 1938, when our city was threatened with catastrophe. The efficient work of the several committees in maintaining communications, rescuing victims of the flood, providing prompt relief to those who had suffered loss, and allaying the fears of our citizens generally by frequent assurance of reliable information, gave a clear demonstration of the worth and the potential strength of the organization.

We are grateful that we were spared a major disaster, and out of the unfortunate crisis we have gained a new confidence and assurance that our Major Disaster Emergency Council is prepared to meet any call, no matter how great it may be or when it may come.

With kindest regards,

Sincerely yours,
Frank L. Shaw, *Mayor.*

* * *

(copy of coördinator's report)

March 10, 1938.

The Major Disaster Emergency Council got a real workout on March 2, 3, and 4. Even though this was not considered a real major disaster, it did give us an opportunity to test our plans.

In making a report of the activities of this Council it must be remembered what the Major Disaster Emergency Council is. It is all the departments of the City Government. The American Red Cross, our public utilities, privately owned corporations, our contractors, supply houses, our hospitals, physicians and surgeons, etc. In fact, everyone in the community who is expected to act in time of disaster has brought themselves together and formed a Major Disaster Emergency Council; a place where they have been able to formulate plans and correlate their efforts. Therefore, it can be readily understood how impossible any single report could be made to cover all the activities of the Emergency Council.

All of the various units of this Emergency Council have made individual reports which cover their particular phases of the program. We then will make our report along more general lines.

This was one of those disasters that developed slowly with no one being able to predict how far it would go. During the first hours it seemed that each problem we were called upon to solve would be the last, until suddenly we came to the realization that we had a tremendous problem before us, and it was a real source of satisfaction to note the promptness with which the various units and individual members of the Council responded.

Early on the morning of the 2nd, Frank L. Shaw, Mayor, and Chairman of the Emergency Council, came to Emergency Council headquarters and took personal charge. Practically every member of the Executive Committee reported either in person or by telephone, and reported that they were in constant touch with the members of their subcommittee and that the entire emergency set-up was standing by; that we might use all or any part of it as the need required.

The telephone communication in the city was excellent. Therefore, it was not necessary to call regular mobilization of all the members.

All departments of the City Government went into action doing their respective jobs, calling upon the Reserves as needed. There was a very close understanding between all departments. There was not a call for Reserves that was not answered promptly, proving that the great amount of planning which had been done was of untold value, and enabled them to locate outside facilities with the minimum of time.

The American Red Cross section was very busy, and began using boats for evacuating homes early. They established refugee camps in Venice, Canoga Park, Van Nuys, North Hollywood, and Tujunga. It was marvelous to see how the various units of this section coöperated one with the other. There was very little lost motion and never a question as to where to find supplies. All the plans of the supply committee proved their worth, as it enabled them to know exactly where to get everything that was needed, such as blankets, cots, food, etc.

An opportunity was given to try out the new committee, known as the Administrative Units, composed of Reserve Army officers working as representatives of the American Red Cross. They moved into five camps and even though the refugees were few they were able to test their plans. Each group made reports of their activities and recommendations for future planning which will enable us to perfect one of the most important groups of the Council.

This was typical of the entire program. We were able to check our planning and, in cost cases, found it good. We found the headquarters needs more telephone lines. This lack of sufficient phone service slowed up the program and caused us to lose a number of calls. This fault is already being corrected.

We found the need of a central intelligence group, where all information regarding the disaster would be assembled. There was need of regular half-hour bulletins and special bulletins, when the occasion required, from the Flood Control, Police Department, Sheriff's Office, Water Department, Public Utilities, American Red Cross, and others who gather information. These bulletins should have been made to a central intelligence group who in turn should release regular news bulletins and clear all rumors, and request for mobilization of various groups, etc. We feel that this would, to a great extent, correct one of our greatest evils in the recent flood, that of wild rumors being broadcast which caused much confusion.

All our people were cared for in a most efficient manner. There was no unnecessary suffering. There was splendid coöperation among all groups in both city and county. I am sure there is no doubt in anyone's mind that the Emergency Council has proved its worth.

BASIL E. RICE,
Director of Coördination.

Concerning California Attorney-General's Opinion on "Health Foundations."

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

Sacramento, California,
March 7, 1938.

To the Editor:—Enclosed please find copy of Attorney-General's Opinion No. NS869, dated February 18, 1938, regarding so-called "Health Foundations," which we thought might be of interest to the readers of CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,
C. B. PINKHAM, M.D.,
Secretary-Treasurer.

(COPY)

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco,
February 18, 1938.

Charles B. Pinkham, M.D.
Secretary-Treasurer
Board of Medical Examiners
450 McAllister Street
San Francisco, California

Dear Sir:

In your communication of the 21st ultimo you enclose a circular issued by a so-called health foundation and ask whether such foundation is violating any of the provisions of the Business and Professions Code.

In reply, please be advised that this office has examined the same and finds that such foundation purports to collect from its "members" a certain sum per month per family, representing that it entitles the member-family to anything the doctor can do in case of sickness or accident; that the member does not pay for surgery; that medical service for any disease whatsoever is purchased for members; that each member is entitled to a complete, free medical examination.

What purport to be facsimiles of letters received by the health foundation under discussion indicate that the health foundation took charge of a case and found three operations on one of the members were necessary; that another member received from the health foundation "the best of medical attention"; that another member received efficient medical service from such foundation.

Such literature indicates that a member thereof is not entitled to a choice of physicians; that the physician in effect is employed and paid by the foundation; that there is no professional relationship between the physician and the patient, and that the scheme of doing business is in accordance with that disapproved by the Supreme Court in the case entitled *Parker* vs. *Board of Dental Examiners*, 216 Cal. 285, and hence is violative of those provisions of the Business and Professions Code prohibiting the practice of medicine under a fictitious name and the aiding and abetting of unlicensed persons in the practice of medicine.

Very truly yours,
U. S. WEBB, *Attorney-General.*
By Lionel Browne (signed)
Deputy.

Concerning Malpractice Policies.

San Francisco,
March 26, 1938.

To the Editor:—Due to the fact that there are a great number of underwriters issuing Lloyd's of London malpractice policies and that these underwriters have, in the past, issued a large variety of policy forms, the following "broad form" of malpractice policy is submitted as the only form of Lloyd's malpractice policy approved as to legal scope of coverage by either the San Francisco County Medical Society or the undersigned. The approval just mentioned has been given *without prejudice* to the policies issued by any other insurance carriers and has reference only to Lloyd's of London, of which, in the past year, some thirty types of policy have been issued.

111 Sutter Street.

Very truly yours,
HARTLEY F. PEART.

(COPY)

A FORM OF POLICY: PHYSICIANS' AND SURGEONS' LIABILITY

In consideration of the statements and agreements in the application for this policy, subject to the conditions and limitations herein contained and in consideration of the payment of the premium, the underwriters hereby agree

A. To pay any damages against———hereinafter called the Assured, for professional services rendered, or which should have been rendered by him and/or any assistant to him, including any partner, physician, dentist, anesthetist, technician, nurse, or any other person, during the term of this policy, and resulting from any claim or suit based upon malpractice, error, negligence or mistake, breach of implied contract, loss of services, property damage, autopsies, inquests, personal restraint, the dispensing of drugs or medicine, assault, slander, libel, undue familiarity, anesthesia hallucination, malicious prosecution, replevin of property or arising from any counterclaims in suits brought by the Assured for the collection of fees provided such damages are claimed under any of the foregoing:

B. To defend the Assured without limit of cost in any suit within the foregoing specifications, filed at any time, and to furnish any bonds not exceeding in amount the minimum limit of this policy, which may be incidentally necessary to such suits, for appeals or the release of attachments or garnishments.

This agreement is subject to the following conditions:

1. The underwriter's liability for damages on account of any one claim or suit shall be limited to———dollars ($———) for each assured. Subject to the same limit for each claim or suit, the underwriter's total liability during one policy year shall be limited to———dollars ($———) for each assured. The cost of defending any suit will be paid in addition to, and irrespective of, the limit expressed above.

2. The underwriters shall not settle or compromise any claim or suit without the written consent of the Assured, and subject to his desire must defend any claim or suit until all legal remedies have been exhausted.

3. The protection under this policy shall include the estate of the Assured.

4. The insolvency or bankruptcy of the Assured shall not release the underwriters from the payment of damages for injuries sustained or loss suffered by any person or persons as the result of an act or omission covered by the policy and occurring while this policy is in full force and effect; and in case execution against the Assured is returned unsatisfied in an action brought by the injured person or his or her personal representative in case of death resulting from such act or omission, because of such insolvency or bankruptcy, then an action may be maintained by the injured person or his or her personal representative against the underwriters under the terms of the policy for the amount of judgment in said action, not exceeding the amount of the policy.

5. The Assured, in the event of receiving notice of claim or suit, shall advise the underwriters or———as soon as possible, and thereafter shall as soon as possible forward to the underwriters' representative any summons or process served, or any information received, and otherwise render the underwriters all assistance possible. All notices and communication to the underwriters and all documents, including summons or other process to be forwarded to the underwriters under the terms and provisions of this policy, shall be delivered to———, California, the underwriters' representative, and delivery of any such notice, communication or document to said representative at said address shall be conclusively deemed to constitute the receipt thereof by the underwriters.

6. The Assured agrees not to contract any expense in a claim or suit under this policy nor to make any settlement thereof without the written authorization of the underwriters and will attend and assist in the defense without charge to the underwriters.

7. The Assured agrees that this policy shall not pay damages awarded in suits based on criminal acts or on services rendered while under the influence of intoxicants or drugs.

8. In any case wherein the Assured has been in attendance or consultation he will endeavor to notify the underwriters before testifying at an inquest or public hearing.

9. Additional doctors engaged by the Assured shall be included hereunder, and an additional premium charged therefor unless insurance is carried in another company. Additional doctors employed during the policy term shall be included hereunder subject to the same conditions and notification to the underwriters and payment of pro rata additional premium.

10. It is agreed that in the event of dispute as to the validity of any claim made by the Assured under this policy of insurance or in the event of any suit instituted by the Assured against the underwriters, or any of them, upon this contract, the underwriters hereon shall submit to the jurisdiction of the courts of the state in which the principal office of the Assured is located and will comply with all legal requirements necessary to give such courts jurisdiction; and for this purpose said underwriters hereby appoint———, ———, California, their agent for the purpose of service of process; and in any suit instituted by Assured against the underwriters or any of them upon this contract, underwriters and each of them will abide by the final decision of the courts of said state and settle accordingly.

11. This policy shall be cancelled at any time at the written request of the Assured or by or on behalf of the underwriters by giving thirty (30) days' notice of such cancellation. If this policy shall be cancelled as hereinbefore provided or become void or cease, the premium having been actually paid to the writers or to the broker who effected the insurance the unearned portion shall be returned on surrender of this policy, the underwriters retaining the customary short rate; except that when this policy is cancelled by or on behalf of the underwriters by giving notice they shall retain only the pro rata premium.

12. The term of this policy begins at noon, Standard time, at the place where the Assured resides and from the——— day of———, 19—, to the———day of———, 19—.

Attached to and forming part of Certificate No.——— Lloyd's, London.

Issued to: ——.

Dated: ———.

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

County Hospitals of California: Powers and Duties of Boards of Supervisors with Respect to Admission of Patients—A Review of Goodall vs. Brite

Recent events in various communities in the State have once again focused attention upon the subject of the extent of the powers and duties of boards of supervisors in the respective counties of the State with respect to the admission of patients to the county hospital and other county tax-supported institutions. In January, 1936, the District Court of Appeal for the Fourth Appellate District decided the case of *Goodall* vs. *Brite*, 11 Cal. App. (2d) 540, which directly involved the subject under discussion, and in which an exhaustive opinion was rendered. It was thought at that time that the court's opinion settled once and for all the seemingly controversial and frequently debated question: What members of the community may lawfully be admitted to tax-supported hospitals? And the further question: Must the decision with respect to eligibility for admission to the county hospital be made before admission, or may it be made at some subsequent time?

Unfortunately, there seems to be some misapprehension even now with respect to the proper legal answers to the questions just stated. Therefore, it is deemed proper to review again the rules of law laid down by the District Court of Appeal in *Goodall* vs. *Brite*.

The case originally arose in Kern County and was an action by individual taxpayers against the Board of Supervisors of Kern County to enjoin the supervisors from admitting to the county hospital as patients residents of the county who were financially able to pay the cost of hospitalization in private hospitals. The theory of the action was that the admission of patients able to pay the cost of private hospitalization constituted conduct on the part of the supervisors in excess of their statutory authority and resulted in an unjustifiable increase in the tax burden of the taxpayers in Kern County. The Superior Court in which the action was originally tried rendered judgment in favor of the taxpayers and against the supervisors and accordingly enjoined the supervisors from continuing to admit patients able to pay the cost of private hospitalization. The supervisors appealed to the District Court of Appeal and that court affirmed the judgment of the Superior Court although it modified the injunction in some respects.

The District Court of Appeal considered a number of questions in reaching its conclusion,* and its opinion on these questions may be summarized as follows:

1. Article IV, Section 31, of the California Constitution, forbids the making of gifts of public funds or the using of public funds for private purposes, and the hospitalization and medical care in the county hospital of residents of the county wholly able to pay for private hospitalization and private medical care constitutes in effect a gift of public funds to such persons.

Hence, Boards of Supervisors violate the California Constitution if they allow residents of the county able to pay for private medical and hospital care to enter the county hospitals. The Court summarizes its position with respect to this point, as follows:

> We, therefore, conclude that the admission and treatment of patients in the county hospital who, either themselves or through legally responsible relatives, can provide themselves with equally efficient care and treatment in private institutions does not promote the health and general welfare of the citizens of Kern County and is not a proper exercise of the police powers of that county and results in the use of public money for private purposes.

2. Residents of the County who are not paupers but who, on the other hand, possess insufficient means either themselves or through relatives legally liable for their support to bear the full cost of hospitalization in private institutions may be admitted to the county hospital as an humanitarian measure. However, with respect to persons who fall within this class, two distinct rules of law must be borne in mind:

(*a*) "Due inquiry and investigation" must be made either by the supervisors or someone on their behalf (*e. g.*, a social service agency) of each applicant for admission to determine whether or not such person is, or is not, able to pay either himself, or through some relative legally liable for his support, the cost of private hospitalization. (One ex-

† Editor's Note.—This department of California and Western Medicine, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

See also editorial comment, on page 234.

* The District Court of Appeal in its injunction provided for the admission of certain special classes of patients such as psychopaths, narcotic addicts, persons in the active stages of tuberculosis, etc., because of special legislative acts providing for the admission of such persons in county hospitals. The main portion of this comment will not include a discussion of these special cases, but in order that there may be no misunderstanding the portion of the court's injunction dealing with these special cases is quoted:

"The following should be admitted: (*a*) an indigent sick or dependent poor person; (*b*) a needy sick and dependent or partially dependent citizen in case of emergency; (*c*) a psychopath, narcotic addict or habitual inebriate temporarily in custody; (*d*) a physically defective and physically handicapped person under the age of eighteen years when the parents or guardian of such person are not financially able to secure proper care or treatment and when such person's admission and treatment has been duly authorized in the manner provided by law; (*e*) a person in the active stages of tuberculosis, in wards established for the treatment of such persons, who is able to pay for such treatment and who, when able to pay, is required to pay for such treatment; (*f*) a person to be quarantined or isolated in the county hospital with a contagious, communicable or infectious disease; (*g*) a prisoner confined to any city or county jail who requires medical or surgical treatment necessitating hospitalization where such treatment cannot be furnished or supplied at such jail when the Superior Court of the county shall have ordered the removal of such prisoner to the county hospital and said prisoner elects not to furnish such treatment at his own expense; (*h*) a county employee injured in the course of his employment by the county when hospitalization is reasonably required to cure and relieve the effects of such injury."

ception to this rule of law arises in cases of emergency or public disaster. This exception will be discussed later.)

(*b*) The supervisors, in administering public funds, are acting as trustees for the general public and, therefore, they are legally bound so to administer the funds as to lighten the tax supporters' burden as much as possible. Therefore, when an applicant seeking admission is found to be partially able to pay the cost of hospitalization, he must be charged an amount which is within his means. Of course, this in no instance can be an amount adequate to cover the full cost to the community of his hospitalization and treatment because if he is able to pay that amount, he should not have been admitted in the first place. On the other hand, if the applicant for admission is able to pay something toward the cost of hospitalization and treatment, he should be required so to pay in order that the taxpayers of the county will not be unduly burdened.

3. The California statutes dealing with powers and duties of Boards of Supervisors with respect to the admission of patients to county hospitals use the term "indigent." In order that this term may have a definite meaning, it is defined as follows:

> The word "indigent" when used in connection with admission to county hospitals includes an inhabitant of a county who possesses the required qualifications of residence, and who has insufficient means to pay for his maintenance in a private hospital after providing for those who legally claim his support. (11 Cal. App. (2d) 550.)

4. In cases of emergency or public disaster such as fire, earthquake, floods, storms or epidemics, people may be injured or rendered suddenly ill and immediate hospitalization may be necessary to save life. In such cases delays in admission to promote investigation of the final condition of the payment might cost loss of life. Therefore, in cases of emergency or public disaster, an exception is made to the requirement of due inquiry and investigation prior to admission, and it is held that:

> Such patients should be admitted promptly, investigation of their ability to pay should follow. Ordinary humanity could dictate no other course. In such cases boards of supervisors should not hesitate to collect the full cost of hospitalization from those able to pay, and from others not able to pay in full, a fair amount, to be determined after an investigation of their resources.

The foregoing summarizes the essential rules of law laid down by the District Court of Appeal in connection with the admission of patients to county hospitals. It is to be noted that the court distinctly and definitely held that the fact of indigency is to be determined upon due inquiry and investigation *prior* to admission to the county hospital except that in cases of emergency or public disaster investigation may be delayed until conditions have returned to normal. A charge may be made by the county in those situations where the applicant is found to be an indigent but is also found to have sufficient funds to pay a portion of the cost to the county of hospitalization and medical care. Only in emergency cases and in the event of a public disaster may patients be admitted without inquiry and investigation and the question of their ability to pay determined afterward.

It must also be borne in mind that the ability to pay of the applicant is to be determined at the time of application, not at some prior date or, on the other hand, at some later date. Moreover, it is indisputable that the State of California has authorized counties to maintain county hospitals for the sole purpose of promoting the public health and welfare of *all* citizens in the respective counties and that the State has limited admission therein to "indigents" because public policy must not countenance use of public funds for the benefit of private citizens who have no *need* for governmental aid. These principles caused the District Court of Appeal to forbid admission of patients wholly able to pay (either themselves or through relatives legally liable for their support) for private hospitalization. On the other hand, these principles likewise must forbid the various boards of supervisors from so administering their public trust that people unable to pay are forever oppressed rather than being protected. The general welfare certainly is not promoted by endeavors to collect from indigents if they later acquire some property. Their progress should be promoted, not impeded.

SPECIAL ARTICLES

CALIFORNIA MEDICAL ECONOMIC SURVEY*

A Statement by the Bureau of Medical Economics [of the American Medical Association]

The California Medical Association in 1934 was accepted by the Federal Emergency Relief Administration as the "Supporting Sponsor" of the California Medical Economic Survey. The published volume contains, as a foreword, the actions which led to the initiation of the report, addenda to the foreword, table of contents, financial reports, letters pertaining to the interpretation of Works Progress Administration regulations, and informal comments concerning possible interpretations and conclusions to be drawn from the factual data.

This survey adds 143 more tables and fifty-seven additional charts to the already large accumulation of figures which has been assembled from time to time under the auspices of various agencies and organizations in an attempt to analyze the need and receipt of medical care and the cost of the medical and hospital services rendered.

Many of the conclusions around which controversy over the distribution of medical services has arisen in recent years are in some way related to the use of the words "adequacy" and "inadequacy." These words are used frequently in the tables of the California Medical Economic Survey but, unfortunately, their use in this survey does not offer much help in a clarification of their application to medical, dental, and hospital care.

A definition of the medical and dental care that is apparently considered "adequate" appears on page 44 of Addendum X.

> The medical and dental care of a population and its members may be called "adequate" if all the following conditions are fulfilled:
>
> 1. In the opinion of qualified experts in public health service and sanitary engineering, preventive and sanitary services intended to diminish the incidence of disease and injury to the whole population are developed to the state of maximum efficiency, *i. e.*, to the point at which curative and other services to all individuals by private or other practitioners become more efficient in preventing damage and more economical of professional personnel and equipment than additional public preventive work.
> 2. In the opinion of qualified practitioners who have knowledge of the persons concerned, curative services and other individual treatment by private or other practitioners are available and obtainable to the whole population at need in the amounts and variety which are necessary or prudent in reducing prospective damage to the person of the patient.
> 3. Additional services for the comfort and convenience of patients—beyond those needed in the reduction of damage—are available and obtainable to the whole population in accordance with the medical and dental habits and customs of the people.

The definition gives one the impression that the first element is a counsel of perfection which, when reduced to a simple statement, seems to mean that medical and dental services, unless developed to a state of maximum efficiency, are unsatisfactory. Webster's New International Dictionary defines adequacy as "equal to or sufficient for some (specific) requirement" and gives as synonyms "proportionate, commensurate, competent, and suitable." The dictionary point of view, which may be supposed to reflect the idea commonly conveyed by the word "adequate," indicates that adequacy always refers to some comparison. In the California survey the purpose for which adequacy is urged is not defined, but the report continuously carries the assumption that adequacy means perfection. Once this assumption is fixed in the mind of the reader of the statistical tables, he is continuously confronted with the question of whether any of the medical services now available are adequate. If, however, the term "adequate" is interpreted as equal to or sufficient for some requirement, then it must have some relation to actualities and environment and to the "adequacy" of other elements which are essential to health, such as food, shelter, fuel, and clothing.

The same lack of definiteness is found with regard to standards or definitions of illness and diagnosis. It appears that the authority for the diagnosis in too large a per-

* Reprinted from *The Journal of the American Medical Association*, February 26, 1938, pp. 117B–119B.

See also editorial comment, on page 236.

centage of the cases was the report of a nonmedical investigator concerning the statement made by the person interviewed, and in many cases it seems that the patient must have made his own diagnosis. Moreover, the same vagueness prevails on the subject of medical treatment. Apparently, the investigators did not ask or were not instructed to inquire as to the length of time that had elapsed since treatment had been received. Nowhere is it apparent that these investigators inquired concerning the nature of the treatment received. This lack of reasonable definition of some of the basic terms used in the survey and the apparent failure to secure some of the basic data pertaining to medical care raise questions as to the value of many of the tables which purport to show "inadequacy" in all these fields.

There is a tendency throughout the published tables to exaggerate the lack of medical care, the cost of such services, and the implied defects of the medical profession, by the arrangement of the tables and the wording of captions. Figure 2 in Table 6 illustrates this point. The population of California used in the survey was based on "California Taxpayers' Association estimates based on average daily attendance in public schools." The Census Bureau of the United States Department of Commerce issues periodic estimates of the population of the states, but there appears no explanation of the use of a local estimate in preference to the Census Bureau estimate of the population. Likewise, the number of physicians in California in 1934 is less by 1,407 than the number given in the 1934 American Medical Directory. In several instances *The Journal of the American Medical Association* and the "Directory of the American Medical Association" are given as sources of information. However, the discrepancy cited is nowhere explained.

The reported need for dental care on date of family interview is shown in Table 25. The percentage of persons of all known incomes in all communities who were reported in need of dental care is given at 9.7. This figure is in sharp contrast with the estimates from a number of other studies which show that the number of persons requiring treatment for caries or other dental conditions seldom falls lower than 75 per cent of the whole population. The number of persons per thousand surveyed reporting specific diseases at time of family interview is shown in Figure 16. The wording of the caption of this chart indicates that these graphs represent the prevalence rates of disease. When compared with the prevalence rates of other studies, the California figures are from about three to more than ten times larger. It is possible that the charts in Figure 16 do not represent prevalence rates as stated in the caption, but are actually the incidence rates for a three-month period. However, if the incidence rate from other studies is compared wherever comparison can be made with the rates in Figure 16, there are still wide discrepancies. If Figure 16 is used to represent the prevalence rate of specific disease, California is depicted as a very unhealthful place in which to live.

The payment of medical bills is shown in Table 47, in which the ratio of expenditures to charges in different income groups is given. It is interesting to note that in a considerable number of instances in which the charges incurred were $40 or less, more than 100 per cent, and in one instance 265 per cent appear to have been paid. There are many who doubtless would be glad to know what device was used to induce patients to pay more than 100 per cent of the charges for medical services.

It is very difficult to reconcile Tables 48 and 116. Presumably, Table 48 represents the percentage balance of family medical debts and charges, and Table 116 represents the percentage of collections of charges for medical services made by physicians. Table 48 indicates that, for all known incomes in all communities, 22.9 per cent of the family debts and charges were unpaid. Table 116 indicates that physicians with all incomes collected 74.1 per cent of their charges for services. Three per cent of all medical charges are thus unaccounted for.

It appears that the sample of physicians on which Figure 31 is based, "Type of Practice of Physicians Reporting," must have been overweighted with specialists. An analysis of the types of practice of the physicians contained in the 1931 American Medical Directory shows that the number of physicians devoting their entire time to a specialty was 19.8 per cent instead of about 33.5 per cent, as shown in Figures 31 and 34. In the 1936 American Medical Directory, 21.9 per cent of California physicians are recorded as devoting their entire time to a specialty. These complete figures for all the recorded physicians in California were available at the time the California Medical Economic Survey was conducted. The California survey figures give a grossly distorted picture of the percentage of general practitioners and specialists in that state.

The relative importance of medical payments among family expenditures shown in Tables 60 and 61, and the average charge per person and family reporting medical charges of zero and over, shown in appendix B-11, give a false impression of the actual amount of medical services received in the various income groups. For example, a charge of $18.53 to an individual in the income group of zero to $499 may represent as much as or more medical care than a charge of $47.10 to an individual in the $3,000 to $4,999 income group. Furthermore, since it appears that a large percentage of the incurred medical bills in the low income groups remain unpaid, neither the size of the medical charges nor the amount actually paid for services by these low income groups can be taken as a dependable measure of the quantity or quality of the services received. Unfortunately, the tables in this survey are arranged in such a manner as to leave the impression that the amount of medical care received in each income group is directly proportionate to the amount of money paid for such care.

The tables and figures in this report give the reader the impression that there has been an effort to arrange a build-up for sickness insurance. If such were the case, scientific interest would have required the inclusion of facts easily available to show the distribution of physicians both as to specialties and as to population by small towns, rural districts, and so on, which is more distorted in any of the countries having sickness insurance than it is in California. The distribution of physicians according to population is no dependable measure of the quantity of medical services available to any specific community. Illness and the means for its relief bear no relation to state or political subdivision boundaries. The use of the population per physician measure of the availability of medical services in California is no more dependable than in any other section of the United States.

The question may well be raised as to the method of conducting the survey and the personnel used to collect the information. Inaccuracies and deficiencies in basic data, collected by persons who have little or no knowledge of medicine, will of necessity be reflected and oftentimes amplified in the finished tables. Perhaps the apparent distortions and discrepancies and the disagreements with other similar studies may be explained in the words of the director—

> In a word, even complacence or ignorance of facts cannot be considered as adequate grounds for maintaining that the picture here presented has been overexaggerated. Rather is the reader asked to put himself in the position of *looking from the viewpoint* of the standard of adequacy expressed above. It is hoped that he will then see, in the data, many of the main features of the real deficiencies in the health services exhibited in a suitable perspective. It is hoped, as indicated in the previous paragraph, that he will also realize he is looking at the picture through a reducing glass.

which seems to mean that the nature and amount of medical care provided by the medical facilities in California are entirely unsatisfactory when evaluated in terms of the definition of "adequacy," used in this survey.

RURAL COMMUNITY HOSPITALS: IS SUBJECT OF NEW FEDERAL BULLETIN*

The shortage of doctors, hospitals, and general medical facilities in certain rural areas is brought out in a bulletin on "Hospitals for Rural Communities" published by the United States Department of Agriculture. The study was made by the Bureau of Agricultural Economics. Blanche Halbert, formerly of the Bureau staff, is the author.

Noting that well-equipped rural hospitals will encourage doctors to enter country practice, the author says that the shortage of doctors in most small rural communities has become a serious problem. In a number of states where most of the people live in the country, there is only one doctor for every 1,000 to 1,500 persons. On the other hand,

* From the United States Department of Agriculture.

in other states which have a large percentage of urban population, there is one doctor to as few as 500 to 700 persons. The number of doctors in rural territory has been steadily decreasing. A great many small towns that had one or two doctors a few years ago have none at present.

As in the case of the doctors, the situation as to hospital facilities likewise places the rural communities at a great disadvantage. A survey made in 1934 showed that only about 1,700 of the 3,073 counties in the United States had any general hospital. This means that 1,300 counties had no hospitals. By allowing two hospital beds per thousand population and a distance of fifty miles from hospital centers, the study showed a need for 22,000 new hospital beds for the rural areas.

The hospital need is said to be greatest in the South, where more than a million persons living in eight states had less than one hospital bed for every 2,000 persons.

The bulletin discusses all the various considerations entering into the planning and building of a rural hospital—the needs of the community, the state laws that affect hospitals and hospital care, what it costs to build and operate a hospital, the financing, and the organization and administration. Numerous sketches show specific plans and specifications, and there are many illustrations of the building and work of rural hospitals in various parts of the country.

"Before agreements are made for a new rural hospital," the author points out that "some idea of the necessary size and expected occupancy should be obtained, for size affects the capital cost and occupancy affects the operating cost. . . . The expected occupancy of a hospital is dependent upon the proportion of beds to the population, the health education of the community and the attending physicians' habits of recommending hospital care."

The author concludes that "A good rural hospital does more than provide for those in the community who actually need hospital care. If it is well equipped and well organized, it may attract physicians to the country district where it is located, and it also may be the means of encouraging the doctors in the locality to stay in country practice. It enables these country doctors to see more patients and do better work. Its laboratories and facilities can be used for the diagnosis and treatment of all people. It may become the center of the entire county health program." A copy of the bulletin, No. 1792 in the Farmers' Bulletin series, may be obtained from the Office of Information, United States Department of Agriculture, Washington, D. C.

GENERAL HOSPITAL FINE INSTITUTION; LET US KEEP IT FINE

Reprint of an Editorial from the Los Angeles Daily News, March 2, 1938

It is to be regretted that at this time, when certain phases of local government are enveloped in a negative perfume, that General Hospital should be in any way open to criticism.

Los Angeles people have always been proud of their county hospital. They ought to be. It cost enough. It is recognized as the finest public institution of its kind in the world for organization, staff, and equipment.

Those who have benefited by treatment there—whose lives would have flickered out in painful misery and amid hopeless squalor if such a grand enterprise did not exist—praise loudly the attention they received; and many do their best to compensate the County, if ever able.

If anything is occurring there to destroy the faith of the people in this great institution—to lessen the pitiable confidence of the indigent, or cast a shadow of suspicion in the minds of the taxpayers—it is a situation that must be instantly remedied.

A county hospital, dealing in a Godly work, should be aloof from politics, venality, acrimony.

If General Hospital is hounding indigents for bills, the practice is cruelly vicious.

If General Hospital is charging, rich and poor alike, in excess of private hospital prices in its fear of being a victim of chiselers, then the County corporation of Los Angeles is a bigger chiseler than its people.

If the County is looking for chiselers, there are plenty of places to hunt for them before picking on the weak and disabled. Far better that one chiseler escape than the wretched lives of the destitute be made more horrible by unfeeling persecution.

* * *

General Hospital is an institution for the people.

In emergency, the doors must swing wide for rich and poor alike, for millionaires and paupers. They are all our people, and it is their hospital—their refuge in dire distress.

Primarily, of course, the hospital is for the poor. It is assumed they have nothing when admitted. But families with monthly incomes of $55 to $125—and there are many—are no more competent to arrange private hospitalization in emergencies than those wholly destitute.

They could, however, in the passage of time, try to diminish the charges at small monthly payments.

It would be reasonable for the hospital authorities to inform a discharged patient that his nominal expense to the County was, for instance, $87.50, and if he can ever pay any part of it, the sum will aid some future patient.

But to hammer at these persons regularly with the threatening tactics of a collection agency, as charged, when they probably are without heat or food, is a heartlessness which could only have been devised by prosperous politicians—who never attack the strong!

The "Kern County decision" of the Appellate Court is given as the excuse for the practice. This ruled that patients must be billed for treatment—but it did not say how often.

Kern County's population can be housed in a city block in Los Angeles. Its indigents can be known by first name to all officials. As a precedent for this county, it is the tail wagging the dog.

Only a leathern legal mind could interpret the Kern decision as it has been interpreted in Los Angeles—a great metropolitan center where destitution is bound to be at a vastly higher proportionate percentage than in a rural district. The interpretation, naturally, came from the office of the county counsel—the top job of which pays $10,000 a year, a fact that was recently emphasized.

Some appointed politicians, who do not need to run for election and have no financial worries, do not have the sympathy for patrons of charity hospitals so necessary for their operation.

* * *

Two hundred physicians are giving part of their time free each week to General Hospital. For the County to charge patients in excess of private hospitals is an affront and injustice to these fine and altruistic men and women.

The current charges were made by Dr. George H. Kress, President of the Los Angeles County Medical Association, which cannot risk its ethical dignity with idle accusations. There must be something there.

The Board of Supervisors will be making a grievous error if it does not press its inquiry to a satisfactory conclusion.

SYPHILIS: THE BARRIERS ARE DOWN—WHAT NEXT*

A Program for 1938

America's golden opportunity to conquer syphilis has been won by twenty years of patient work. At last the barriers are down. In the daily press, in national weeklies and monthlies, in radio broadcasts, in addresses and conversations, syphilis and gonorrhea are now discussed frankly and with optimism. The United States Public Health Service, under the vigorous leadership of Surgeon-General Thomas Parran and with the coöperation of the medical profession, has accelerated official action against these diseases throughout the country.

These are advances for which the American Social Hygiene Association has striven continuously—that the light of science might reveal to needlessly suffering men and women the hopeful facts regarding syphilis and gonorrhea; that the resources of local, state, and national governments might be mobilized against preventable disasters.

General interest, feelings of sympathy aroused by accounts of tragedies chargeable to syphilis and gonorrhea, are futile unless organized and directed in a program of specific action. No program for wiping out syphilis can succeed that fails to come to grips with the problems of individuals in shops, factories, offices and homes, in cities and on the farm. Infected persons must be treated, sources

* By Walter Clarke, M.D., Executive Director, American Social Hygiene Association.

of infection found, contacts examined, men and women instructed in the nature, methods of spread and means of prevention of syphilis and gonorrhea. For these purposes facilities and services available to all must be provided in cities and towns throughout the country. This program and these facilities must be provided under local medical and health agencies and to the extent necessary out of local tax funds. The people of the communities must appreciate the need for them and must wish to provide them. In a word, there must be organized citizen support based on enlightened citizen understanding.

For more than two decades the American Social Hygiene Association, guided by its General Director, Dr. William F. Snow [one-time Director, California State Board of Public Health], has gone about the business of creating and organizing this citizen interest and support. The time has now come to extend and intensify this work. Perhaps not for another generation will an equal opportunity be given America to conquer syphilis and mitigate the ravages of gonorrhea. The public will soon tire of a problem about which little is done; and the old inertia and hopelessness will return, unless popular awareness and concern are promptly capitalized. To capitalize this interest, we must organize it and put it to work.

The Association, aided by its National Anti-Syphilis Committee, of which General John J. Pershing is chairman, will redouble its efforts to create and organize support of the modern scientific program against syphilis and gonorrhea. The practical steps to be taken in cities, towns, and states are these:

1. Create committees of leading citizens to sponsor and guide appropriate action in coöperation with and support of the medical and public health forces of the community.
2. Instruct the public regarding syphilis and gonorrhea, the damage they cause, and how to prevent their spread.
3. Encourage sound official efforts to combat syphilis and gonorrhea.
4. Study local and state problems of syphilis and gonorrhea and social conditions favoring their spread, and plan to deal effectively with them.
5. Promote a well-rounded scientific program and obtain adequate facilities for combating syphilis and gonorrhea.

There is a place for every citizen, for every professional group, for all phases of interest in social hygiene, in such a program of state and local action. Both "the old guard, and the new recruit," as President Ray Lyman Wilbur calls them, are needed here. The Association will continue to work through existing state and local voluntary agencies, especially social hygiene societies, in organizing citizen support for the campaign against syphilis. In collaboration with these, the Association will provide the services of trained field workers as organizers, and of consultants for the technical features of the program. Where no social hygiene societies exist, the Association's representative will utilize the organization and contacts of appropriate existing agencies where these are made available, adding to them state and local committees for specific action against syphilis and gonorrhea. Failing such coöperation with existing health agencies, the Association may recommend new organizations of whatever type may seem to all concerned most satisfactory under the circumstances. As previously, the Association will continue as central clearing house of advice and information and will develop and disseminate educational material in appropriate variety and keyed to the current public interest.

This is our practical working policy and program for the immediate future. Along this highway let us make as rapid progress as possible, working in close harmony with health authorities, the medical profession, and social and educational organizations; not losing sight of nor abating activities related to the great ultimate objectives of the founders of the Association, but concentrating on the attainment of our first goal—the conquest of syphilis.

"In giving full approval to this emphasis on the medical aspects of social hygiene during 1938, and doubtless also for several years to come, the Association is not ignoring the importance of its long-range program of sex education and preparation for parenthood and family life," says Professor Maurice A. Bigelow, Chairman of the Executive Committee. "Nor is it overlooking the pressing problems of prostitution faced by many cities in a more acute form now than at any time in the last decade."

Constantly the Association points out that it is "combating syphilis and gonorrhea *and the conditions which favor their spread.*" Conditions which favor their spread include not only lack of facilities for diagnosis, treatment, epidemiology and popular health instruction, but also commercialized prostitution, sordid and degrading amusements, ignorance of parents and others responsible for the sex education of youth, handicaps of homes, schools, and churches in motivating boys and girls with high ideals of conduct.

The spear point of the social hygiene movement at present is the campaign against syphilis and gonorrhea. Behind the spear is the solid body of the whole broad social hygiene program giving weight and steadiness to the drive against these diseases. That will still remain after syphilis and gonorrhea have taken their places, along with smallpox, typhoid and yellow fever, cholera, and soon tuberculosis and diphtheria, among the vanquished enemies of man.

CALIFORNIA VENEREAL DISEASE CONTROL—PAST, PRESENT, AND FUTURE

The Venereal Disease Act of California was passed by the Legislature in May, 1937, was signed by the Governor on July 1, 1937, and became a law on August 27, 1937.

The Act appropriated $150,000 for the biennium. This is supplemented by $72,000 allocated to the state for venereal disease control by the United States Public Health Service for the fiscal year 1937-1938. In addition, approximately $200,000 has been appropriated by local governmental agencies for the present fiscal year for venereal disease control.

ADMINISTRATION OF THE ACT

Under the provisions of the law, the Bureau of Venereal Diseases was created as a separate bureau within the California State Department of Public Health. The state program is administered by the State Department of Health under the direction of Dr. Walter M. Dickie, director of the department. The Bureau was reëstablished (since such a bureau was in existence from 1917 to 1920) on February 1, 1937, and Dr. Malcolm H. Merrill was appointed as chief of the Bureau, using funds allotted to the state by the United States Public Health Service. (The Bureau was thus established prior to the passage of the state legislation.)

The Bureau of Venereal Diseases functions as an integral part of the State Department of Public Health just as does the Bureau of Epidemiology, Bureau of Tuberculosis, Bureau of Food and Drug Inspection, etc.

Accomplishments to date are difficult to evaluate. Some of the more evident developments may be mentioned.

1. *Reporting System.*—The system for reporting cases of venereal diseases has been simplified and modernized. A new report form has been prepared and issued. This new card was issued the latter part of June, at which time it was forwarded with a letter of explanation to the 12,500 medical practitioners in California.

Cases Reported.—The number of cases reported has increased by approximately 50 per cent since these cards went into use. The total number of cases reported to the end of the third week in December were 16,361 cases of gonorrhea and 16,540 cases of syphilis or a total of 32,901 cases. Twenty thousand of these cases have been reported since July 1, 1937. These figures may be compared with a total of 23,843 total cases in 1936 and 23,591 total cases in 1935. This does not indicate an increased prevalence, but better coöperation of the physicians in reporting. Surveys that have been carried on have indicated that prior to the present campaign less than 10 per cent of the cases treated by private physicians were rejected.

The epidemiological reports constitute a vital part of the reporting system. A card folder has been prepared and issued for this purpose. Each time a physician reports a case of venereal disease the local health department sends one of these card folders, together with literature for the patient, to the physician. On these folders the physician reports sources of infection, contacts and cases lapsing from treatment. The local health department then investigates these cases. Already many infections have been prevented as a result of these investigations. These cards have also been mailed to all physicians in the state. This entire reporting system, together with printing of cards, and instructions to physicians, have been developed in the past nine months.

2. *Clinics.*—When the Bureau was established, thirty-five venereal disease clinics were reporting at monthly intervals to the state department. The number has increased to seventy-seven. The records in many clinics were found to be poor and inadequate; wide variations existed. In order to improve the standard of the records and treatment, clinic record forms were prepared, printed and made available to any clinic desiring to use them.

Many clinics were treating only patients fulfilling the requirements of residency, and in many attendance of all patients was discouraged. Almost all clinics have now adopted the policies concerning admission laid down by the Bureau of Venereal Diseases, namely:

(a) Any patient for initial diagnosis and emergency treatment.

(b) Any case referred by a private physician for special tests and consultation.

(c) Any patient honestly unable to pay a private physician for treatment. Residency requirements completely abolished.

The next step has been to improve the general standard of medical care within the clinics. The Sacramento City Health Department Clinic was selected to determine the workability of various procedures of record keeping, treatment schedules, nursing procedures, etc. A medical officer of the Bureau has been assigned to that clinic for the past three months. A complete reorganization has been effected. As a result of the fine coöperation of the city of Sacramento, the clinic has been remodeled, all admission fees abolished, all residency requirements eliminated and any patient desiring advice is courteously received. After diagnosis is made, patients that can afford private medical care are referred to private physicians.

The same general plan is being inaugurated in the Fresno County Hospital Clinic beginning on January 3, and will be extended as rapidly as possible to all clinics in the state that will coöperate with the state department.

A unique plan of supplying physicians to these clinics has been worked out with the United States Public Health Service. Young physicians are employed by the state department as probationary public health workers and assigned to these clinics to devote their full time. As soon after employment as possible, these clinicians will be given a three months' intensive postgraduate course in the clinical management and public health control of venereal diseases. It is anticipated that each year to eighteen months, a new group of physicians will be employed to replace the trained physicians who go out into practice.

The State Department of Public Health is assisting these clinics by providing equipment, clinic record forms, in some instances, drugs and personnel.

Seventy-seven clinics now reporting to the state department are administering approximately 25,000 treatments per month to indigent patients of the State of California. The report for November indicated that 25,023 treatments were given to about 11,000 patients. In these clinics, 8,186 Wassermann tests were run, 4,453 microscopic examinations for gonococcus were made, and 134 darkfield examinations for treponema pallidum were made. On a yearly basis, this will indicate approximately 300,000 tests a year. Surveys have indicated that approximately 25 per cent of cases are being treated in clinics and 75 per cent by private physicians.

3. *Nursing Personnel.*—The addition of nursing personnel to the staff to take care of epidemiological work has had to await the Civil Service examinations. Within the next month it is anticipated that twelve to fifteen such nurses can be assigned to various districts throughout the state to develop this phase of the program. Two such nurses have already been assigned to the San Francisco Health Department. Heretofore this phase of the work has been almost entirely lacking throughout most of the state.

4. *Distribution of Drugs.*—Efforts are being made to render treatment of nonclinic patients easier to obtain. Private physicians are being provided with drugs for the treatment of indigent and part-pay patients. Since July 1, sufficient medication for approximately 50,000 treatments for syphilis has been dispensed by the Bureau of Venereal Diseases.

EDUCATIONAL ACTIVITIES

Physicians.—An addressograph list of all physicians in the state has been prepared. Thus far two circular letters have gone out to physicians with enclosed cards and pamphlets.

A number of lectures have been presented before county medical society groups and there have been several showings of the United States Public Health Service film, entitled "Syphilis of the Central Nervous System, a Preventable Disease."

Pamphlets.—A series of seven pamphlets have been issued. Thus far approximately 125,000 pamphlets have been sent out from the state department. Over one-half of these have been mailed directly to individuals as a result of requests.

Lectures.—Approximately fifty lectures have been delivered by various members of the department on Venereal Disease Control.

The United States Public Health Service film, "Syphilis: Its Nature, Prevention, and Treatment," has been shown to over fifty audiences.

Pamphlets have been mailed to all libraries in the state and all have been advised to obtain copies of Dr. Thomas Parran's book, entitled "Shadow on the Land, Syphilis."

Laboratory Activities.—The activities of the state and local health department laboratories have been extended. The number of tests being run have increased by approximately 100 per cent in the past year. This same increase is reported by private laboratories.

In an effort to improve the standards of laboratory service throughout the state a service is to be developed within the state laboratory in which specimens will be sent out to various laboratories for examination and check made upon the accuracy of these examinations. This is an extension of the general policy of the United States Public Health Service in which state laboratories are subjected periodically to such checks on the accuracy of their diagnostic tests.

PLANS FOR 1938

(a) *Continuation and Extension of Clinic Plans.*

(b) *Marked Extension of Epidemiological Services.*

(c) *Development of Educational Centers.* Venereal disease training centers will be established and there will be an extension of training service offered to professional groups throughout the state. This applies particularly to the young physicians being added to the venereal disease bureau staff, who will receive three months of specialized training some time within the next year.

(d) *Marked Extension of Educational Program.* For the month of January an intensive educational program is being promoted throughout Southern California. A number of special posters are being prepared, particularly small enameled posters which will be distributed by the thousands throughout the state. These posters will be available for posting within the near future. There will be marked extension of lecture service, motion-picture showings and other types of educational activity.

(e) *Extension of Activities to More Rural Districts.* There will be marked extension of the program to the rural districts of the state, particularly with reference to the distribution of free drugs and arrangements for the care of indigent patients either through the establishment of clinics or through arrangements with local physicians to take care of these cases.

(f) *Seminars—County Medical Societies.* A series of seminars is already being planned for county medical society groups, to be carried on during the months of May and June. The services of Dr. Udo Wile, Professor of Dermatology and Syphilology of the University of Michigan Medical School, have been obtained for this purpose.

(g) *Surveys.* A number of surveys designed to determine the prevalence of venereal diseases have already been carried out in several counties of the state. These have indicated that there are between four and six cases per thousand of population constantly under treatment for these diseases. These services will be extended to include several of the larger cities of the state and to cover much of the rural districts of the state. They are designed to provide the department with more accurate information as to the extent of the problem and the points that can be most effectively attacked.

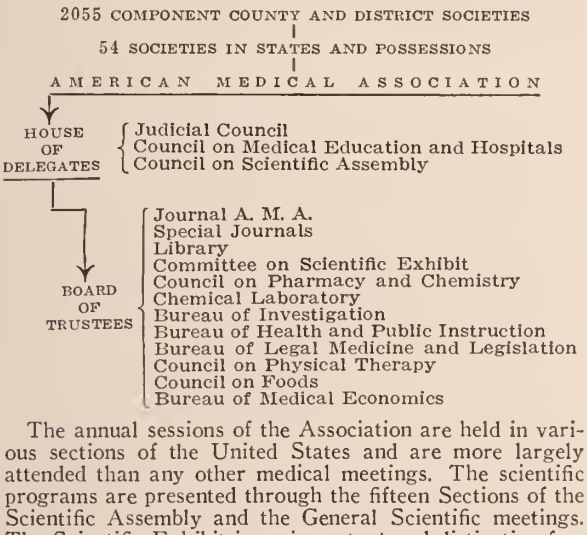
(h) *Personnel.* The present personnel of the Bureau is as follows: Chief of the Bureau, two medical officers, two investigators, an educational director, an addressograph operator and mail clerk, two nurses, two stenographers, and one venereal disease clinician. The personnel will be extended primarily by the addition of public health nurses and physicians. It is anticipated that some additional technicians will be employed to assist in the laboratory work.

THE INDIVIDUAL PHYSICIAN AND THE AMERICAN MEDICAL ASSOCIATION

Why a Fellow?—"Why should I be a Fellow of the American Medical Association?" "In what way do its activities affect me, the individual practitioner of medicine?"

These are fair questions. Those who have qualified for Fellowship have a right to ask for evidence that the Association is functioning actively in the interests of physicians. The following partial inventory of its activities is, therefore, presented. It shows in a brief way what the American Medical Association means to physicians individually and to the profession in general. Every physician who is a member in good standing of his county and state medical societies is a member of the American Medical Association and thus is eligible to apply for Fellowship. None but Fellows are eligible for election as officers of the Association or to participate in the work of its scientific sections.

How the American Medical Association Functions.—A large, nation-wide organization must necessarily delegate its activities to smaller bodies or to individuals. The House of Delegates of the Association determines its policies. The Board of Trustees is the governing body in the interval and is charged with the duty of administering the affairs of the Association. The various activities and the bodies responsible for each are shown in the following diagram.



The annual sessions of the Association are held in various sections of the United States and are more largely attended than any other medical meetings. The scientific programs are presented through the fifteen Sections of the Scientific Assembly and the General Scientific meetings. The Scientific Exhibit is an important and distinctive feature each year, averaging over two hundred individual and special exhibits dealing with advances in scientific medicine. The Technical Exhibit is always comprehensive and complete. Many enjoyable social functions are provided for Fellows and their wives.

The work of the American Medical Association is carried out largely through its executive officers, its various councils, its bureaus and its publications, which are described in detail in the following pages of this booklet.

The Judicial Council.—Jurisdiction on all questions of ethics and in the interpretation of the laws of the organization comes under the purview of the Judicial Council. It deals with questions involving Fellowship in the Scientific Assembly or the obligations, rights and privileges of Fellowship; controversies arising under the Constitution and By-Laws to which the Association is a party; controversies between two or more constituent associations, between a constituent association and a component society of another association, or a member or members of another constituent association; and controversies between members of different constituent associations. The Judicial Council is composed of five members, elected for five years.

Council on Medical Education and Hospitals.—This Council has brought the standards of medical education to a basis by which they are recognized throughout the world. Through its activities college entrance requirements have been raised to a reasonable point, college sessions have been lengthened, courses reorganized, better buildings and laboratories secured, better equipment provided, including libraries and museums, more and better teachers employed, better clinical material obtained and more improved methods of teaching adopted. Detailed information concerning all schools is maintained in the secretary's office. Undergraduate institutions are inspected and rated as "approved" or "not."

The Council informs physicians as to where they can secure satisfactory graduate medical courses in the various departments of medicine and surgery, whether in America or abroad.

The Council has also elaborate facilities through which detailed information in regard to all medical students and physicians is regularly collected, and kept on file. This makes it possible to recognize and support the legally and educationally qualified professional man and to expose quacks, healers, impostors, and incompetents. In short, the Council stands as a guard to keep the medical field from being overrun and discredited by entrance of the unfit. Its resources have been used with telling effect.

Another important phase of the work done by the Council on Medical Education and Hospitals is the collection and dissemination of information about hospitals. It maintains: (*a*) a list of hospitals registered by the American Medical Association; (*b*) a list of hospitals that are approved for internships; (*c*) a list of hospitals offering approved residencies in medicine, surgery, pediatrics, obstetrics, and the other specialties; and (*d*) lists of recognized schools for the training of occupational, physical therapy, and laboratory technicians. The Council also maintains standards for the approval of examining boards for the certification of specialists.

The Council will give you information about ratings of medical colleges, hospitals and other medical institutions; postgraduate courses; residencies; internships; licensure; reciprocity; information and statistics on medical education, licensure, hospitals, and technical schools.

The Council on Scientific Assembly.—This body is charged with the responsibility and duty of arranging the programs of the general meetings of the Scientific Assembly and securing coöperation between the sections. Other functions are to consider at first-hand applications for new sections or for changes in existing sections; to pass on questions of policy in relation to scientific work, and to investigate and report on scientific questions; and to appoint officers for meetings making up the section on miscellaneous topics, and for the first session of a newly established section. This Council consists of five members, each elected for five years.

Biographical Department.—Since 1905 this department has been collecting personal data regarding medical graduates and licensed physicians for a biographical card index of physicians of the United States and Canada. These records are available to all Fellows of the Association. They enable members of the profession to keep tab on location, society affiliations, specialty teaching connection and other personal data concerning colleagues. These data may be obtained either by writing to the Biographical Department or by consulting the American Medical Directory, which is issued every two years. It is a reliable, authentic register of the members of the profession.

Council on Pharmacy and Chemistry.—Through the Council on Pharmacy and Chemistry, the Association offers protection to physicians in choosing proprietary remedies. Seventeen scientific men, each an authority in his special field, make up the Council. Newly introduced medicinal preparations are considered in the light of cold, scientific evidence. The findings are reported in *The Journal of the American Medical Association* and in the book, "New and Nonofficial Remedies," issued annually. Here the physician can check up on claims made for medicinal preparations which he may be urged to use. In many cases, the Council finds that certain remedies marketed under proprietary names are no more efficacious than the established United States Pharmacopoeia products. Such products are sometimes sold at exorbitant prices, as compared with those of pharmacopoeial products. Many preparations are discovered to be irrational mixtures, many utterly inefficient for the purposes for which they were made. Fellows of the Association are privileged at any time to obtain information relative to medicinal preparations.

Council on Physical Therapy.—The Council on Physical Therapy was established with the primary purpose of gathering and disseminating such information as will assist

(Continued in Back Advertising Section, Page 38)

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 4, April, 1913

From Some Editorial Notes:

Why Not More Such Meetings?—On February 22 there was held, at Del Monte, the annual gathering of the Monterey County Medical Society and the Monterey County Bar Association. It was a good meeting, a good banquet and a very good idea inspired it; anything that will get doctors to mix with other professions, is unqualifiedly good.

In a number of counties there are good, live medical societies and bar associations; why not steal this idea from Monterey and get together once a year for a joint session of well mixed wit and wisdom? Surely we can each learn something from the other, even if it is only the fact that the other fellow is not so bad after all!

* * *

Lost Arts.—A rather interesting article, recently read, referred to the lost arts of our ancestors. No longer the housewife spins and weaves; no longer the family soap is made from the family grease and lye leached from the family ashes; no longer the candles are dipped by the hearth during the long evenings; no longer does autumn see the wonderful laying down of that immense quantity of mincemeat "like mother used to make." Passed are these things with the passing of the buffalo robe, the wild turkey and the prairie chicken. Has the art of prescription writing passed from us also? Has pharmacy taken the place of pharmacology? Have the patent office and the manufacturing pharmacologist taken the place of the thoughtfully put together prescription? Are the simple and valuable things of olden times buried out of sight by the flood of "discoveries"? For a simple "stiff neck" a quite new and wonderfully medically educated physician prescribed a new purgative, aspirin and a new lotion. Three dry cups, in ten minutes time, relieved the condition entirely. In what medical school does one find a knowledge of simple and valuable things properly expounded to the students? Is all this progress really advance?

* * *

Doctors and Lawyers.—Unfortunately, there is a very general impression in the public mind, and in the minds of a great many physicians as well, that the professions of law and medicine are very much alike, as they relate to the public in general and hence should be subjected to legislative control in quite similar ways. Even no less a person and so able a lawyer as Governor Johnson, in his message to the Legislature at its opening, voiced this thought and referred to the fact that a lawyer practicing in one state can go to another and practice with but little formality and no difficulty; he is not subjected to an examination before being permitted to practice law, so why should a physician be examined before being licensed to practice medicine? After a little thought, the fallacy of the argument in comparison becomes evident.

From an Article on "Rational Psychotherapy" by H. C. McClenahan, M.D., San Francisco.—The reasons for presenting this paper are threefold:

1. The necessity for a better and more scientific understanding generally of the principles, indications and application of psycho-therapeutic measures.

2. The disposition of many to regard attempts at such treatment as unscientific, irrational or even questionable.

3. The failure or refusal of some to use mental measures, as such, independently of, or in connection with, other treatment when indicated.

(Continued in Front Advertising Section, Page 15)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

Board Proceedings

"Three reappointments and one new appointment to the State Board of Medical Examiners were announced today by the Governor's office. Named to succeed themselves for terms ending on January 15, 1942, were: Dr. Percival Dolman, San Francisco; Dr. George Thomason, Los Angeles; and Dr. C. L. Abbott, Oakland. Dr. John MacLean of Los Angeles replaces the late Dr. Harry V. Brown of Glendale. (San Francisco *News*, February 3, 1938.)

* * *

The Board of Medical Examiners held a regular meeting in Los Angeles, March 7 to 10, inclusive, 1938. Sixty-five applicants appeared for written examinations, including physicians and surgeons, chiropodists, and drugless practitioners. Twenty-one revoked licentiates applied for restoration. Three applied for modification of the terms of their probation.

Twenty-five cases were on the calendar for legal hearings. The following changes were made in the status of licentiates:

Licenses Restored

Harry Asher, chiropodist, license revoked on October 19, 1937, for practicing beyond the limitations of his certificate. Restored on March 8, 1938, and placed on probation for a period of five years. (Previous entry, December, 1937.)

James H. Beggs, M.D., license revoked on February 10, 1937, following conviction in the Pacific Coast abortion trials; restored on March 7, 1938, based upon the Supreme Court's setting aside the judgment of conviction and granting Doctor Beggs a new trial. (Previous entries, February, 1928; July, October, and December, 1936; February and June, 1937.)

Ralph A. Behrend, M.D., license revoked on October 19, 1937, based upon adjudication of insanity; restored March 8, 1938, and placed on probation for a period of five years, without narcotic privileges.

John V. Cocke, M.D., license revoked on July 10, 1935, narcotic dereliction; restored March 9, 1938, placed on probation for five years without narcotic privileges and prohibited from using intoxicating liquors. (Previous entry, October, 1934; August, 1935.)

Arthur Lee Davis, M.D., license revoked on July 11, 1933, for narcotic dereliction; restored on March 9, 1938; placed on probation for five years without narcotic privileges. (Previous entries July and August, 1933.)

Thomas Flint, Jr., M.D., license revoked on February 11, 1937, for narcotic dereliction; restored on March 9, 1938; placed on probation for a period of five years without narcotic privileges. (Previous entries, May, June, and October, 1936; February and March, 1937.)

George W. Fuller, M.D., license revoked on July 10, 1934; restored on March 8, 1938. Probation five years. (Previous entries, January, February, 1935; July, 1937.)

Darrington Weaver, M.D., license revoked on July 9, 1931 (narcotic conviction). Restored on March 9, 1938. Placed on probation for five years without narcotic privileges. (Previous entries September, 1937; July and August, 1931.)

Licenses Revoked

Sharon M. Atkins, M.D. (Medical-Chemical Laboratories, Robert Armstrong), charging of aiding and abetting an unlicensed practitioner; license revoked on March 9, 1938.

John Elmer Baker, M.D., convicted in Los Angeles insurance fraud; license revoked March 10, 1938. (Previous entries, July and September, 1927; April and December, 1928; September and December, 1937.)

(Continued in Front Advertising Section, Page 17)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

ONLY THESE SOLUTIONS ARE VACOLITER PROTECTED



B A X T E R ' S

INTRAVENOUS SOLUTIONS IN VACOLITERS

Here—solutions must be right

Solutions must be made sterile, yes . . . but they must *stay* sterile until your patient receives them. To assure purity and sterility in the intravenous solutions you use, Baxter's Laboratories developed the Vacoliter . . . a container specifically designed to protect its contents from the ever present hazards of contamination, deterioration and change in pH value.

A strong metal cap seals your solutions in a vacuum until you are ready to use them. No one can tamper with the closure without leaving unmistakable evidence. Once opened, a Vacoliter can never be resealed. This is an added protection against damaged fluids. This is one of the many reasons you can use Baxter's Dextrose and Saline Solutions with confidence in their dependability. They come to you after their sterility and purity have been thoroughly tested.

Only Baxter's Solutions are Vacoliter protected. Add economy to these satisfying advantages and the three basic advantages of Baxter's Solutions stand tall and obvious: They are sterile and pure; they are economical; they are *convenient to use* in the patented Vacoliter.



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The Denver Fire Clay Co. *Denver-Salt Lake City*
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The Ohio Chemical & Mfg. Co. *San Francisco*
Shaw Supply Co. . *Tacoma-Seattle-Portland*
Southwestern Surgical Supply Co. *Phoenix*
Spokane Surgical Supply Co. . . . *Spokane*

IN CONVALESCENCE

It's More Calories

PROPERTIES OF KARO

Uniform composition
Well tolerated
Readily digested
Non-fermentable
Chemically dependable
Bacteriologically safe
*Non-allergic
Economical

*Free from protein likely to produce allergic manifestations.

•

COMPOSITION OF KARO

(*Dry Basis*)

Dextrin	50%
Maltose	23.2%
Dextrose	16%
Sucrose	6%
Invert sugar	4%
Minerals	0.8%

•

KARO EQUIVALENTS

1 oz. vol.	40 grams 120 cals.
1 oz. wt.	28 grams 90 cals.
1 teaspoon	15 cals.
1 tablespoon	60 cals.

Convalescent children show a low metabolism for several weeks following the disappearance of an infectious fever as a consequence of generalized cellular damages.

The high caloric diet is indispensable. It is made possible by reinforcing foods and fluids with Karo. Every article of diet can be enriched with calories derived from Karo.

Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.



FREE *to Physicians only:*

Convenient Calculator of Infant Feeding Formulas; accurate, instructive, helpful. On receipt of Physician's prescription blank, giving name and address, the Calculator will be forwarded. Write Corn Products Sales Co., Dept. SJ-4, 17 Battery Place, New York, N. Y.



FRANKLIN
HOSPITAL

Limited General Hospital with accommodations for 220 patients located in a seven-acre park. Fourteenth and Noe Streets, San Francisco.

Fully approved by the American College of Surgeons and the American Medical Association for Interne Training, and maintaining an Accredited School of Nursing.

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WALTER V. ROHLFFS, Ph. D.
President

LeROY BROOKS, M. D.
Chief of Staff

FRANK SCHMIDT
Superintendent

(Continued from front advertising section, page 31)

essential minerals and vitamins which may be lacking in less varied food supplies.

"When diets are largely made up, as is often the case in this country, of grain products, meats, fats, and sweets, they may satisfy the appetite and the traditional demand for variety, and yet fall far short of present-day specifications for satisfactory diets," said the speaker. "They may furnish plenty of protein and plenty of fat and carbohydrates in good proportions, but without liberal quantities of vegetables and fruits, and of milk in its various forms, they cannot furnish optimal quantities of some of the minerals and vitamins."

After discussing results of recent surveys of food consumption in typical groups of families in urban and rural communities, Doctor Stiebeling said that this analysis emphasizes three main points: "the need for greater purchasing power among the low income groups; the tendency of families to buy more of the protective foods and to secure better diets as the level of expenditure for food rises; and the wide difference in the nutritive quality of diets now purchased at any level of expenditure above a certain irreducible minimum."

For the country as a whole, she said, the findings of nutrition studies suggest "the allocation of a somewhat higher proportion of the income to food in view of greater appreciation of the long-time significance of dietary adequacy," and also "the more efficient use of money now devoted to food, through wider dissemination of knowledge regarding food values and nutritional needs."

Influenza.—Many are the years that have come and gone and many are the generations that have vanished since the first authentic account of an influenza epidemic was written. Mankind in that far-distant time lived in close touch with the supernatural, and old world science had no quarrel with angel or demon, so the good things of life came as reward, the evils as punishment.

For Acidity and Allied Conditions, we suggest
ADAMS SPRINGS MINERAL WATER



● MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of the seven known iron and maganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is *marked* drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

A Natural Mineral Water
SHOWING MAIN CONSTITUENTS
By PROF. SYDNEY A. TIBBETTS, *Berkeley*

MANGANESE	1.3 parts per million
IRON	12.5 parts per million
CALCIUM	173.3 parts per million
MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

For further information write W. R. PRATHER, D. D. S.
ADAMS SPRINGS, LAKE COUNTY, CALIFORNIA

Steam heated hotel, open all year around.

3000 feet up in the Lake County Pines.

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This belief, firmly and universally held as it was, should have tuned human behavior to an extremely high moral pitch, but history and experience show that the realization of good to follow certain actions, or even the fear of evil consequences following others, never materially changed man's way of living.

The first authentic account of an influenza epidemic was written in 1173 A. D. and since that time this, the greatest of humanity's epidemic scourges, has killed millions of helpless victims. It is estimated that in the pandemic which swept the world in 1918 and 1919 there were 200,000,000 cases and 10,000,000 deaths. In the United States alone there were more than 20,000,000 cases and 450,000 deaths. In India 4,933,132 deaths were reported from June to November, 1918.

Influenza is transmitted from person to person by the secretions of the mouth and nose by coughing, laughing,

(Continued on Next Page)

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• The Hydropathic Department devoted to the treatment of general diseases excluding surgical and acute infectious cases. Special attention given functional and organic nervous diseases. A well equipped clinical laboratory and modern X-ray Department are in use for diagnosis.

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(Continued from Preceding Page)

sneezing, and other means which make possible the transference of fresh virulent material from the infected person to the nasopharynx of the person with whom he is in contact.

The short period of incubation—twenty-four to forty-eight hours—and the almost universal susceptibility to the disease make the progress of an epidemic appear as an overwhelming explosive attack rather than one of communication, yet study of various epidemics has shown that the less intimate the contact and the more isolated the communities the more slowly does an epidemic travel.

Influenza spares neither age nor sex, class nor race; the rich and the poor are apparently equal in susceptibility. Practically everyone knows this and also just how it is transmitted, yet there remains a fundamental obstacle to all control measures, inasmuch as ordinarily people do little or nothing for their own protection and if precaution is taken at all it must be the affected person who exercises it. How carefully this is done may be seen by observing the run-of-mine individual with a cold. So influenza remains the one outstanding disease which proves that mass and group control can go only so far, and that, until a method of active immunization shall have been discovered, there is little chance of protection against its spread, because human nature will not change, and it is a very exceptional citizen indeed, who, when ill of the preliminary symptoms of influenza (even when he recognizes them as much), regards the safety of his neighbor as a personal responsibility. Many epidemic diseases, after sweeping through a community and temporarily exhausting the fuel that makes their progress possible, leave the victims who recover protected against future recurrence; not so with influenza; no previous epidemic prepares man to resist subsequent attack, and in fact there seems to have been an added susceptibility.

The symptoms of influenza range from those of a mild common cold to high fever, severe backache and sudden prostration, and its principal danger is the development of pneumonia as a complication. It is particularly dangerous at the extremes of life.

Precautions

Keep as far as possible from those who cough and sneeze.

Avoid unnecessary contact with those who have the disease.

Do not use drinking or eating utensils used by others unless such utensils have been thoroughly washed and rinsed in boiling water.

Avoid crowded places so far as possible.

Wash the hands frequently with soap and water.

Avoid unnecessary fatigue.

At the first sign of infection, go to bed.

Call a physician and obey orders.

Fatal Nicotine Poisoning.—The United States Department of Commerce, Bureau of the Census, records 288 cases of fatal nicotine poisoning in the United States Registration Area for the years 1930-1934, inclusive. In Portland, Oregon, over a ten-year period, according to Beeman and Hunter, there have been twenty-two deaths directly attributable to the ingestion of nicotine insecticides. The report also states that nicotine ranks fourth among the different poisons responsible for accidental, homicidal, and suicidal deaths over a ten-year period ended in September, 1936. The observations in eight necropsies are described. The essential lesions were of two types: those showing hemorrhagic gastritis, with or without the odor of nicotine, and often a brownish discoloration of the gastric mucosa, giving the picture of gastritis following the ingestion of a mild caustic; and those without gastritis, but showing an acute failure of the right side of the heart without any exact anatomic basis for death. In those cases in which an adequate history was obtained, it seemed that collapse occurred shortly after ingestion of the poison, death being deferred for from five to thirty minutes. Convulsive phenomena and a typical posture, however, were conspicuously absent. In an attempt to determine the effects of nicotine and Black Leaf 40 (a common insecticide), guinea pigs were utilized. The animals receiving Black

(Continued on Page 38)

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

II. THE BLANCH

● Previously, we have described the reasons for the thorough cleansing of raw food materials prior to canning and the methods by which such cleaning is effected. Another basic operation in the commercial canning procedures for many vegetables and some fruits, is known as the "blanch". (1)

In essence, the blanch is an operation in which raw food material is immersed in warm or hot water, or exposed to live steam. The blanch serves a multiple purpose.

First, blanching serves to soften fibrous plant tissue. By so doing, it contracts or expands these tissues and thus insures a proper final fill in the tin container. Second, during the blanch, respiratory gases contained in the plant cells are liberated. This release of gas prevents strain on the can during heat-processing and favors development of a higher vacuum in the finished product.

Third, the blanching operation inhibits enzymes naturally present in the raw foods and prevents further enzymatic action. Inhibition of enzymes—particularly those inducing oxidative reactions, yields products of superior quality and nutritive values. Fourth, the blanch may serve as an added cleansing measure and also remove "raw" flavors from certain foods. A final function of the blanching operation is to fix or set the natural color of specific products.

In commercial canning practice, blanching is usually accomplished in equipment especially designed for certain types of products. In general, the raw products after thorough washing are conveyed through water or steam by various mechanical devices capable of adjustment so as to subject the raw materials to a particular temperature for the proper period of time.

Such, in broad detail, are the purposes and mechanics of the blanch, a basic operation in many commercial canning procedures.

AMERICAN CAN COMPANY

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(1) 1937 Appertizing or The Art of Canning,
A. W. Bitting,
The Trade Pressroom, San Francisco.

This is the thirty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



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All Owl Stores have modern and fully equipped pharmaceutical departments.

(Continued from Page 36)

Leaf 40 exhibited a longer latent period before the onset of the convulsions, and the convulsions were of lesser intensity than in those animals receiving 40 per cent nicotine alkaloid. All died with fixation of the respiratory muscles, the heart continuing to beat. A dilute solution of sodium hydroxid adjusted to the total alkalinity of the Black Leaf 40 sample failed to produce the same severe gastric changes. It was concluded as a result of these studies that, because of the violent toxic action and ready accessibility of nicotin, commercial preparations such as Black Leaf 40 should be subject to the statutes covering the sale of poisons and their sale by nonpharmaceutical dealers prohibited. Observations of this nature should be given careful consideration in the formulation of any new food and drug acts that may be adopted.—*Journal of the American Medical Association.*

THE INDIVIDUAL PHYSICIAN AND THE AMERICAN MEDICAL ASSOCIATION

(Continued from Text Page 303)

the medical profession in determining the therapeutic value of certain devices and methods employed in the administration of physical therapy and of protecting both the public and the conscientious manufacturer against fraud and misrepresentation. The Council consists of clinicians, physicists, physiologists, pathologists, radiologists, and surgeons, each a specialist in his particular field.

Apparatus for physical therapy is considered and reported on in *The Journal.* A list of the devices that have been investigated and reported on in accordance with the Official Rules of the Council may be obtained from the office of the secretary at headquarters. A series of articles on physical therapy has been published in *The Journal.* It clearly sets forth the known merits of physical therapy and therapeutic agents. The most important articles of the series have been assembled in the "Handbook of Physical Therapy." Through these authoritative articles the Council has in a large measure divested physical therapy of the unwarranted therapeutic claims and the absurd theories with which it has been burdened.

The reports and recommendations of the Council are of great assistance to the physician in selecting efficient apparatus and methods of treatment.

Council on Foods.—The Council is authorized to utilize the influence and prestige of the American Medical Association for the establishment of truthful advertising of foods, and to act in the interest of the public on food matters. Voluntarily submitted foods, accompanied by complete advertising and information on formula of ingredients, analysis, microörganisms content, definition or specifications of raw materials used, description of manufacture, caloric value, vitamin content, and compliance with food laws, are scientifically passed upon and appraised. Foods which meet the Council's requirements as foods and which are properly advertised and promoted, are listed as "Accepted Foods." Manufacturers of "accepted" foods are privileged to display the seal of the Council on the package labels and in advertising, and are obligated to maintain their products and advertising in full accord with the Rules and Regulations of the Council.

The Council is effecting extensive changes in food advertising so that it will properly instruct the public on food values, nutrition and "health" through correct diet. The natural food values of certain foods are being protected. Decisions of the Council on its requirements for individual foods and on promotional advertising are being published to guide the food industry and advertising agencies.

From time to time the Council sponsors publication in *The Journal* of authoritative and informative monographs on various nutritional subjects.

The office of the Council receives many requests and inquiries from physicians, the food industry, and advertising agencies, and acts as a clearing house on matters pertaining to foods and food advertising. The advertising of foods in the Association's publications conform to Council decisions.

(Continued on Page 40)



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THE INDIVIDUAL PHYSICIAN AND THE AMERICAN MEDICAL ASSOCIATION

(Continued from Page 38)

Chemical Laboratory. — The American Medical Association Chemical Laboratory is a well-equipped department for the chemical investigation of newer remedies as presented to the medical profession and for various types of analyses. Much of its work is for the Council on Pharmacy and Chemistry in the evaluation and standardization of those medicinals which the Council has deemed worthy of consideration by the medical profession; in this work there is often coöperation with the manufacturer. For the Bureau of Investigation it supplies chemical data, which are incorporated in many of the "patent medicine" exposés. Original investigations along lines which will be of service to the profession at large are undertaken. It also aids *The Journal of the American Medical Association,* various organization committees, and replies to inquiries from physicians.

The Laboratory serves as a clearing house for information on the many new additions to materia medica, particularly the complex synthetics. Its value to organized medicine in America is clearly demonstrated when comparisons are made to the unscientific "chemistry" often presented to the profession in other countries which do not possess an impartial advisory laboratory. The Laboratory is so overwhelmed with requests for work that it confines its activities to those preparations which are widely advertised and to the investigation of the newer remedies for the Council on Pharmacy and Chemistry. It does no work for individual physicians and, of course, it does no commercial work. Members of the Association, however, are invited at any time to write for such chemical information as the Laboratory possesses in its extensive files.

Bureau of Investigation.—The Bureau of Investigation is a clearing house of information on "patent" and proprietary medicines, all forms of quackery, medical fads and fakes. The practical value of this material is proved by the thousands of letters of inquiry that are received annually by the Bureau of Investigation. These come from physicians and laymen in every state in the Union and from various foreign countries. Any physician desiring specific information on some preparation is urged to write to the Bureau asking for details and facts. Each letter of this kind is given careful answer, and in the majority of cases it is possible to send information on the subject of his inquiry.

Should a physician want to give a talk before a local club on some phase of the "patent medicine" evil or quackery, the Bureau of Investigation has a number of inexpensive pamphlets furnishing a wealth of material from which to prepare addresses. Also, the physician may rent lantern slides for a nominal fee that can be used effectively in illustrating talks on such subjects. In addition, there are a number of educational posters that have been prepared by the Bureau of Investigation and can be purchased at small cost. Physicians should not only take advantage of the service offered by the Bureau of Investigation, but should urge their patients who may inquire about certain "patent medicines" and quacks to write to the Bureau for information.

Bureau of Health and Public Instruction. — The Bureau of Health and Public Instruction divides its work into two principal functions: (1) service to the public through physicians and medical societies; (2) direct service to the public. The aim of both is health education of the public. Service to medical societies and physicians is rendered through personal attendance at state and county medical society meetings; reprints dealing with techniques and principles in health education; prepared radio talks available to the medical profession; loan of *Hygeia* clipping collections to aid physicians in preparing speeches, and liaison contacts with important governmental and voluntary agencies, both medical and lay, for the discussion of health policies bearing on medical practice. Service direct to the public consists in a correspondence answering 15,000 questions annually for lay inquirers; a radio network program forty weeks each year on a network of the

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National Broadcasting Company; local and network radio broadcasts for special occasions; personal appearances and speeches before allied professional nonmedical groups, such as teachers; personal appearances and speeches before luncheon clubs, women's clubs and other community groups, especially high school assemblies; contributions on health topics to *Hygeia* and other reputable health magazines and lay magazines of general circulation; close coöperation with the Bureau of Exhibits, furnishing material for visual presentation; gathering and dissemination of information on public health, health education, protection of medical research, and promotion of the periodic health examination.

Bureau of Legal Medicine and Legislation.—This bureau keeps in touch with legislation and court decisions of interest to physicians. Information collected by the Bureau is available to all Fellows and members of the Association through their respective state medical societies.

The American Medical Association, however, cannot consistently with law and the ethics of the legal profession give legal advice concerning specific problems of purely personal import.

Bureau of Exhibits.—The Bureau of Exhibits has to do with the scientific and educational exhibits of the Association.

The Scientific Exhibit at the annual session of the American Medical Association covers all phases of scientific medicine, as well as the medical sciences. The exhibits are presented by leading physicians and research workers of the country, who personally demonstrate their work throughout the week of the meeting. Fellows of the Association attending the meeting may confer at length on those subjects in which they are interested.

Exhibits dealing with the activities of the various councils and bureaus of the Association have been prepared also for loan purposes to state and county medical societies or to groups approved by those societies. Some of the exhibits are strictly scientific and are intended only for medical meetings; other exhibits are of a popular nature and may be used at fairs, expositions and other places where

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(Continued from Preceding Page)

the public may gather. A list containing some forty subjects, with a description of each exhibit, may be had upon request.

Several motion pictures on scientific subjects are available for medical societies upon request. A list of sources of motion pictures, both for medical societies and for the public, is available.

Bureau of Medical Economics.—This Bureau was established to study all phases of general economics which have a bearing upon the practice of medicine. The Bureau is attempting to collect, tabulate, study, criticize, and to prepare for publication and distribution, data pertaining to the economics of the practice of medicine; to furnish both critical and constructive information and opinions by correspondence, conferences, and addresses on the several phases of medical economics; to encourage the adoption by individual physicians and medical societies of modern, sound, ethical business methods to urge medical schools to provide medical students with information concerning the economics of medical practice and an outline of essential business principles which should be incorporated early in individual practice.

The reports of studies conducted by the Bureau are published from time to time in the organization section of *The Journal*. Information concerning collection agencies, health and accident insurance companies, companies writing insurance against malpractice, corporations, coöperatives, associations and companies providing contract medical service, and such other data pertaining to the economics of medicine, is kept on file for answering inquiries.

American Medical Association Library.—The library of the American Medical Association is planned primarily as a reference library for the headquarters office and for rendering service to the medical profession. More than 1,300 medical journals, domestic and foreign, are regularly

(Continued on Page 46)

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One author* writes: "A maternity corset not only aids in disguising the pregnancy figure but also is of great value in preventing a number of the complications of pregnancy. It should support the abdominal wall, the spinal column and the pelvic girdle. By supporting the abdominal wall, it holds the growing uterus in place. ... the contour of the abdomen wall will be better preserved... .With the back supported, the change in posture due to the forward displacement of the uterus is less fatiguing and many backaches are eliminated. Similarly, support of the pelvic girdle prevents sacroiliac strain with its accompanying pain and backache."

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*BECK, page 98, "Obstetrical Practice," published by the Williams and Wilkins Co., 1935.

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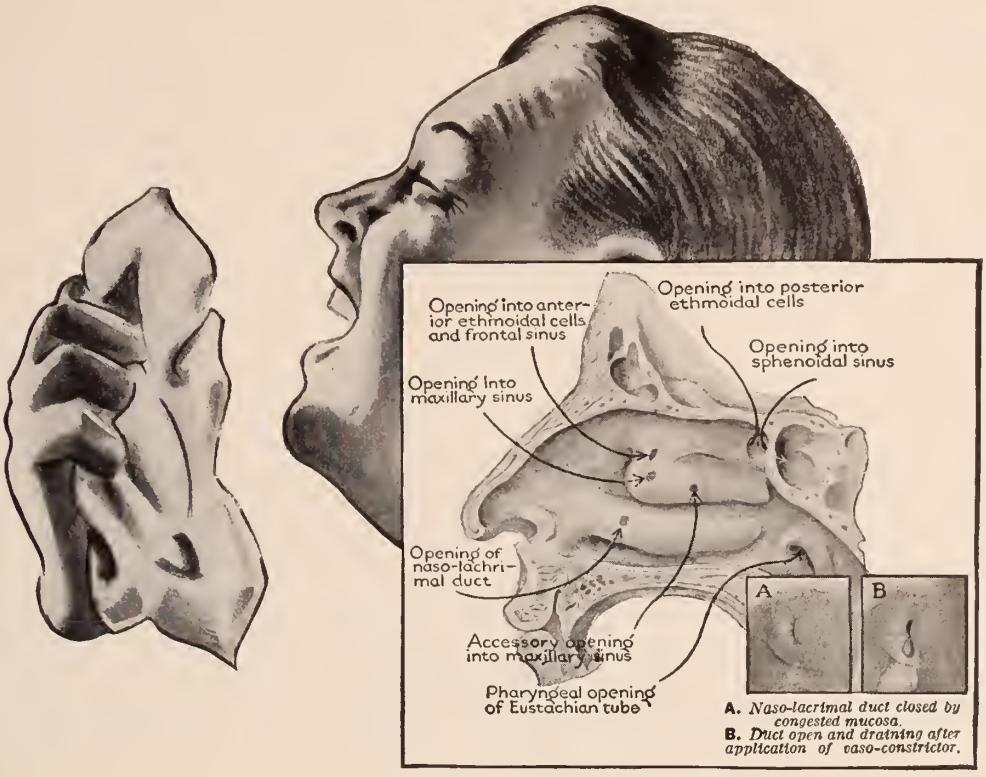
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received, many of them abstracted and indexed. The abstracts are made available to physicians through the columns of *The Journal.* An index of articles currently published, by both subject and author, is provided through the Quarterly Cumulative Index Medicus.

Reference Library Service. — Any member of the American Medical Association may use the facilities of the library, which will supply him on request with periodicals, package libraries or bibliographic service. Journals on file in the library may be borrowed for three days on request, accompanied by six cents to cover cost of postage. Through the package library service, members of the Association may secure, for temporary use, reprints of original articles on general medical subjects. A fee of 25 cents is made to cover postage.

Publishing Deparment.—By operating its own printing plant, the Association is able to furnish medical publications at a great saving. This department includes extensive type equipment, linotype machines, flatbed and rotary presses and necessary bindery machinery for producing medical journals, books, pamphlets, and supplies on a large scale, and at a reasonable cost. For example, the weekly issues of *The Journal of the American Medical Association* in one year make a total of more than 4,000 pages of reading matter attractively illustrated and well printed on good quality paper. The price is but $7, including Fellowship dues. *Hygeia,* the lay health journal, at $2.50 per year, is printed on the Association's presses and compares in typography, illustrations, and general attractiveness with other high-grade magazines. The printing department also makes possible several special journals—Archives of Internal Medicine, $5 per year; American Journal of Diseases of Children, $8 per year; Archives of Neurology and Psychiatry, $8 per year; Archives of Dermatology and Syphilology, $8 per year; Archives of Surgery, $8 per year; Archives of Otolaryngology, $6 per year; Archives of Pathology, $6 per year; and Archives of Ophthalmology, $8 per year. Journals such as these necessarily have a limited appeal and would have to carry a much higher subscription rate if printed by private concerns. This also applies to the Quarterly Cumulative Index Medicus, which gives the user a reference to practically all worth while articles currently published in the world's medical journals, yet is furnished at a price of $12 per year.

The American Medical Directory is another publication made possible by the facilities of the Association. This is issued every two years. It is a book of about 2,500 pages.

(Continued on Page 48)

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★*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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(Continued from Page 46)

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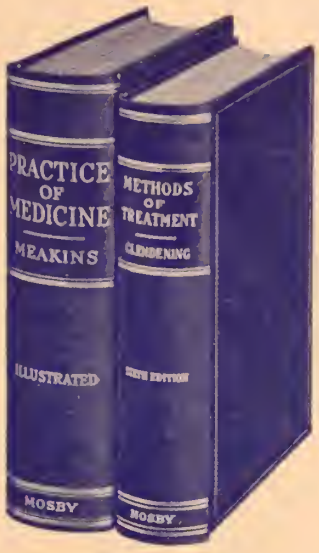
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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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The Fly in History.—It was at the close of a summer day in the year 442, A. D. Lysippus, a battle-scarred old noble of the emperor's household, had just been condemned to die. This is the reason:

The emperor, Theodosius, had wed, one year ago this day, Eudocia, the learned and beautiful daughter of Leontius, the sophist, and the anniversary banquet had been in progress all the hot and sultry afternoon.

About the festal board were many guests. There were many attentive slaves, there were numerous watchfully waiting, active dogs, and there were flies! There were flies in myriads.

Fiery old Lysippus, whose head was thatched with practically nothing but the impalpable laurels he had won in the wars, finally driven to desperation by the buzzing pests, brought down a broad, weighty palm on his smooth and glistening dome, and three perfectly good flies passed to the great beyond.

Up 'rose Eudocia horrified; up 'rose Theodosius, dignified. Lysippus grinned; that finished him.

These people were good Christians; they did not worship flies, but it had been distinctly made known at Eudocia, greatly versed in the lore of Greece and Rome, in astronomy, in astrology, rhetoric, logic and what not, desired, and in fact demanded that flies be carefully protected throughout the empire. She knew flies.

She had proved by logic that the fly was the friend of man, because, where men most congregated, there were found most flies; where filth was most abundant, there were flies most busily active as scavengers in man's service, etc.

No one could outargue Eudocia. And, above all, there was the mysterious, magical origin of the fly which placed it as a creature apart. The fly suddenly popped forth fully developed into energetic existence apparently from nothing at all or perhaps from a little slime or mud by some sort of spontaneous generation, an origin accorded no other living thing except possibly the frog, toad, and snake. Eudocia had her doubts about these; they were not useful anyway. However, let us be sorry for old Lysippus; he lived and died too soon.

We now know there is nothing mysterious about the origin of flies. If flies are about, there is filth somewhere in the neighborhood because the eggs from which flies hatch are incubated in filth. Filthy places are the fly's habitat by preference, and filth provides his natural sustenance. If there is any reason for a fly's existence it is not known, unless it may be as Blinkowitz suggests in his treatise *The Friendly Fly*: "The fly's existence may be justified by the possibility that, as nature has so kindly fitted him out as an ideal germ carrier and distributor; man, having knowledge of this, may be led to clean his premises."

The fly's chief business activities are apparently propagation and the dissemination of the germs of typhoid fever, tuberculosis, summer diarrhea, diphtheria, erysipelas, anthrax, conjunctivitis, and gangrene. It might be mentioned, also, in the fly's favor: he is dipterous—two-winged; if he had more wings, he would get over more territory, be more filthy, and do more damage by carrying more germs.

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Look at the fly you are entertaining at lunch today, and ask yourself where he or she has previously dined, then calculate the number of undesirable germs and the varieties of unmentionable filth particles his or her descendants may carry to your family when summer days arrive.—*Ohio Health News.*

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From February, 1938, issue of "San Francisco County Medical Society Bulletin" and March, 1938, issue of "California and Western Medicine," articles on "Malpractice Insurance."

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Handbook on Eye Hazards in Industry Available at Specially Reduced Price.—To secure wider distribution of its book on "Eye Hazards in Industrial Occupations" by Louis Resnick and Lewis H. Carris, the National Society for the Prevention of Blindness, Inc., 50 West Fiftieth Street, New York City, is now offering copies at the special price of fifty cents each as long as the supply lasts. This book, which sold formerly at the actual cost price of $1.50 was published in 1924. Although some of the photographs show safety devices which have since been improved upon, the contents remain a valuable guide to safe practices in industry.

The volume contains 247 pages, and includes fifty-nine illustrations dealing with the safeguarding of eyesight in factories, mines, shops, and offices. Orders or inquiries concerning this volume should be addressed to the National Society for the Prevention of Blindness, 50 West Fiftieth Street, New York City.

The inventors of the alphabet could not have foreseen the odd uses to which their signs and symbols would some day be put: how a man might read to take his mind off a mortgage, to make a journey seem shorter, to kill ennui, to rest the mind after an emotional storm, or to lull himself to sleep at night. If you would develop powers, read not often merely to pass the time, for listless reading breeds a poor memory.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Management of the Sick Infant and Child. By Langley Porter, B. S., M. D., M. R. C. S. (Eng.), L. R. C. P. (Lond.), Dean, University of California Medical School and Professor of Medicine; formerly, Professor of Clinical Pediatrics, University of California Medical School; Visiting Pediatrician, San Francisco Children's Hospital; Consultant to the San Francisco Department of Public Health, San Francisco, California; and William E. Carter, M. D., Director, University of California Hospital Out Patient Department; formerly, Chief of Children's Clinic, University of California Hospital, San Francisco; Attending Physician, San Francisco Hospital; Attending Physician, Los Angeles County Hospital. Fifth revised edition. Cloth. Pp. 874, illustrated. Price, $10. St. Louis: The C. V. Mosby Company, 1938.

Hernia. Anatomy, Etiology, Symptoms, Diagnosis, Differential Diagnosis, Prognosis, and the Operative and Injection Treatment. By Leigh F. Watson, M. D., Member of Attending Staff of California Lutheran Hospital and Methodist Hospital of Southern California, Los Angeles. Second edition. Cloth. Pp. 591, illustrated. Price, $7.50. St. Louis: The C. V. Mosby Company, 1938.

Workbook in Elementary Diagnosis for Teaching Clinical History Recording and Physical Diagnosis. By Logan Clendening, Professor of Clinical Medicine, University of Kansas. Cloth. Pp. 167, illustrated. Price, $3.00. St. Louis: The C. V. Mosby Company, 1938.

The New International Clinics. Original Contributions: Clinics; and Evaluated reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Volume 1, New Series One (old forty-eighth). Cloth. Pp. 322, illustrated. New York: J. B. Lippincott Company, 1938.

The Practice of Urology. By Leon Herman, B. S., M. D., Professor of Urology, University of Pennsylvania, Graduate School of Medicine; Urologist to The Pennsylvania Hospital and to the Bryn Mawr Hospital; Consulting Urologist to the Methodist Episcopal and Burlington County (New Jersey) Hospitals. Cloth. Pp. 923, with 504 illustrations. Price, $10 net. Philadelphia: W. B. Saunders Company, 1938.

Men Past Forty. By A. F. Niemoeller, A. B., M. A., B. S., Author of American Encyclopedia of Sex, etc. With a Foreword by Winfield Scott Pugh, B. S., M. D. Cloth. Pp. 154. Price, $2.00. New York: Harvest House, 1938.

Proceedings Occupational Disease Symposium. Northwestern University Medical School. Paper. Pp. 86. Chicago: Northwestern University Medical School, 1938.

On Thought in Medicine. By Hermann Von Helmholtz. An address delivered August 2, 1877, on the Anniversary of the Foundation of the Institute for the Education of Army Surgeons. Introduction by Arno B. Luckhardt. Reprinted from Bulletin of the Institute of the History of Medicine, Vol. VI, No. 2, February, 1938. Paper. Pp. 27. Price, 75c. Baltimore: The Johns Hopkins Press, 1938.

The Heart in Pregnancy. By Julius Jensen, Ph. D. (In Medicine), University of Minnesota, M. R. C. S. (England), L. R. C. P. (London), Assistant Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician to Barnes Hospital; Physician to St. Louis Ma-

(Continued on Page 15)



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Berkeley: Diseases of Women (6th Ed.)	6.00
Kracke: Textbook of Clinical Pathology	6.00
MacKee: X-Rays and Radium (3rd Ed.)	10.00
Spivak: Surgical Technic of Abdominal Operations	10.00

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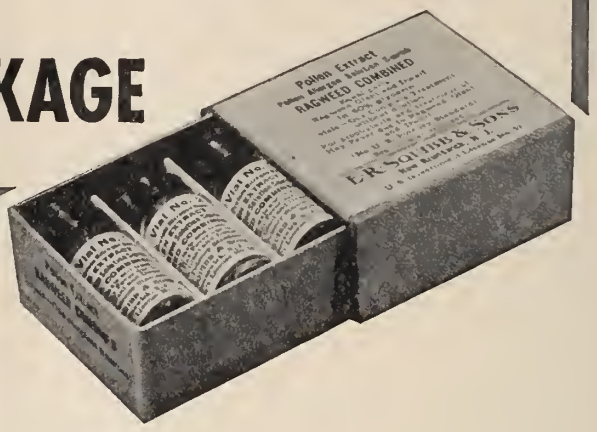
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BOOKS RECEIVED

(Continued from Page 13)

ternity Hospital and St. Louis City Hospital. Cloth. Pp. 371. Price, $5.50. St. Louis: The C. V. Mosby Company, 1938.

Annual Report of the President of Stanford University. For the Forty-sixth Academic Year ending August 31, 1937. This being the Thirty-fourth Report submitted, to which are appended annual reports of the Comptroller, Departments, Committees, and Publications of the Faculty. Paper. Pp. 550. Stanford University: Stanford University Press, 1937.

Symptoms of Visceral Disease. A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine. By Francis Marion Pottenger, A. M., M. D., LL. D., F. A. C. P., Medical Director, Pottenger Sanatorium and Clinic for Diseases of the Chest, Monrovia, California; Professor of Clinical Medicine, University of Southern California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration," etc. Fifth edition. Cloth. Pp. 442, with eighty-seven text illustrations and ten color plates. Price, $5.00. St. Louis: The C. V. Mosby Company, 1938.

Hemorrhoids. By Marion C. Pruitt, M. D., L. R. C. P., S. (Ed.), F. R. C. S. (Ed.), F. A. C. S., Atlanta, Georgia. President, American Proctologic Society; Associate in Surgery, Emory University School of Medicine; Proctologist, Grady Hospital, Crawford W. Long Memorial Hospital, Georgia Baptist Hospital, and Atlanta Antituberculosis Association; formerly Resident Surgeon, Westminster Hospital, London, England. Cloth. Pp. 170, with seventy-three illustrations, including seven in color. Price, $4.00. St. Louis: The C. V. Mosby Company, 1938.

A Textbook of Pathology. Edited by E. T. Bell, M. D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Third edition, enlarged and thoroughly revised. Cloth. Pp. 894. illustrated with 412 engravings and two colored plates. Price, $9.50. Philadelphia: Lea & Febiger, 1938.

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BOOK REVIEWS

Management of the Sick Infant and Child. By Langley Porter, M. D., and William E. Carter, M. D., both of the University of California Medical School. Fifth revised edition. Cloth, 874 pages. Price, $10. C. V. Mosby Company, St. Louis.

There is made available in this fifth revised edition of an appreciated text, modern principles related to the management and care of the sick infant and child. It is indeed a welcome addition to the literature. It will be welcomed also by many students and practitioners.

The authors have acknowledged the assistance rendered in writing the text by a distinguished group of associates of the University of California Medical School.

The field is covered thoroughly and in a manner that leaves little, if any room for disappointment. It is specific in discussion and advice. Extended comment on methods of treatment constitute a valuable feature. It should serve as a guide and reliable reference, and be of material assistance when confronted with complex problems encountered in the sick child.

Hernia. By Leigh F. Watson, M. D., Los Angeles, California. Second edition. Cloth, 591 pages. Price, $7.50. C. V. Mosby Company, St. Louis.

This text, and it is an excellent one, presents the important features of the anatomy, etiology, symptoms, diagnosis, differential diagnosis, prognosis and treatment of hernia. Mention should also be made of the concluding chapter, the medical legal aspects of hernia which is well to the point.

A well tempered, but nevertheless thorough chapter presents the indications and technique of treatment of certain types of hernia by the injection method.

Illustrations are well selected and are of a type that increases the value of the text. Subjects are well selected, impress by the clarity of the text, and emphasize basic important features.

All in all the author has furnished a text and guide that will be most helpful to surgeons and physicians. Unreserved recommendation is given for this book, is wholly consistent, and based on sound principles.

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

Workbook in Elementary Diagnosis. By Logan Clendening, M. D., University of Kansas. Cloth, 167 pages. C. V. Mosby Company, St. Louis, Mo.

This is a teaching guide for history recording and physical diagnosis. A satisfactory outline for students and clinic clerks.

Hemorrhoids. By Marion C. Pruitt, M. D., Atlanta, Ga. Cloth, 170 pages. Price, $4.00. C. V. Mosby Company, St. Louis, Mo.

An excellent monograph, well illustrated and comprehensive in text. Should be helpful to the general practitioner as a guide in treating this condition under sound principles. Merits general endorsement.

Symptoms of Visceral Disease. By Francis Marion Pottenger, M. D., F. A. C. P., Pottenger Sanitarium, Monrovia, California. Cloth, 442 pages, fifth edition. Price, $5.00. C. V. Mosby Company, St. Louis.

This author will arrest the attention of his many California as well as national friends and confreres who recognize him to be an authority of experience on any subject that he discusses.

In this monograph, the first edition appearing in 1919, there is presented a study of the vegetative nervous system in its relationship to clinical medicine. Pottenger presents interpretations in terms of visceral neurology of the symptoms which are found in visceral disease. He demonstrates how pathological changes in one organ affect other organs.

Little more need be said. Every earnest physician will find this monograph to be of great assistance to him. It merits a place in every medical library and should be consulted frequently.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 392)

stetrics) and Murphy (of *Murphy's Clinics*)—or should it be Murphy and Martin?—started the game and have skillfully encouraged the ambition to belong to something and decorate one's name with letters. How are the honored ones to be chosen? From the subscription lists of *Murphy Clinics* and *Surgery, Gynecology and Obstetrics*? Or shall the applicant merely have to attend and register at one of these huge surgical Martin-Murphy clinics?

* * *

Wassermanns and Wassermanns.—Judging from the circulars sent out by various laboratories, it would seem as if the price of Wassermann reactions had at last reached a sane level. The high prices asked by some serologists a couple of years ago have undoubtedly led to the sprouting up of a number of new laboratories. The reduction in price will permit far more frequent tests than heretofore.

* * *

Improving Medical Education in the United States.—At the time of writing, the state legislature has before it a number of bills, all destructive of the present medical law and not evidencing any proper compensatory constructive intent. Moreover, the administration itself is favorable to changes in the law which will lessen, in great measure, its value to the people. Finally, the people themselves, they who are the most interested in a proper medical law whether they acknowledge it or not, are quite indifferent to their own fate in the premises.

This puts, in a very few words, the *status præsens* in California and the prospect is not a satisfactory one. It is, then, a great relief to turn to the current annual report of the president of the Carnegie Foundation and to read his review of the general medical situation in the United States and in Canada, and see what has been gained and how much it is, and how really nothing has been lost in the wider field which must include the narrower.

Statistics are said to be just as truthful as facts, and so these statistical facts are quoted in full: "The total of 166 schools of all kinds existing in the United States and Canada in June, 1904, has in eight years decreased to 117 in 1912. Homeopathic schools, of which there were twenty-two in 1900, have now fallen to ten; eclectic schools from ten to six; the physiomedical schools have entirely disappeared. The total student enrollment, which reached 28,142 in 1904, has now declined to 18,412. As the student bodies of the higher grade schools have steadily advanced in numbers, this considerable decrease has taken place precisely where in the public interest it should take place, namely, in the weaker schools. It is thus obvious that the destruction of one inefficient school does not merely result in increasing the enrollment of another; it actually and absolutely keeps a certain number of unfit men out of the profession." The "negative character"—as it is called in the report—of these facts does not detract one whit from their having a positive value in indicating the trend of events. Leaving present forces undisturbed to continue this work and making "sure that standards are genuine rather than higher" in the immediate future will accomplish what is needed quite regardless of any vagaries of any state legislation.

From an Article on "On the Relation of the Academic Medical School to the Medical Community" by H. C. Moffitt, M. D., San Francisco.—It is unfortunate for us all that engagements of President Wheeler prevent his being here this evening—it is for you particularly unfortunate that I have been selected to speak in his place. We shall reach a better understanding if, at the start, it is determined what is meant by an "Academic Medical School." It is a question that has been discussed in detail by such men as R. M. Pearce, Cabot, Edsall, Huntington, Barker, Hewlett, and that is, in some of its aspects, familiar to you all. For some years it has been a fact generally accepted that the work of the first two years in medicine must be in the hands of men who could devote all their time to their special de-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

partments—unhampered by the cares of practice—men who would be teachers but above all investigators, active in the advancement of medical development and knowledge. With the acceptance of this fact began the passing of the proprietary school; no institution dependent upon fees of students alone can long furnish the right men and proper equipment for the work and laboratories of the first two years. With the advances in student preparation and the standards of the first years in medicine, with the tremendous widening of the whole medical horizon, it soon became apparent that instruction in the so-called scientific branches was developing faster than the teaching of the clinical years, sometimes developing even at the expense of the clinical years. The gap widened between "scientific" and clinical departments, and it became necessary to find men with more time to devote to the development of the clinical years. It was realized that, as soon as practical, clinical teachers must be paid for part or for all their time, that the practicing physician could no longer cope unaided with the situation, that the last years of medicine needed the special teacher, organizer, investigator, even more than the first.

DISCUSSION

President Jordan: You understand, of course, that I am a medical impostor, so do not expect me to tell active physicians anything of medicine they do not already know. I took my medical degree with Harvey Wiley thirty-seven years ago, when bacteriology had not escaped from the Greek Lexicon, when germs and microbes were undreamed of, when pharmacology was a branch of metaphysics; and obstetrics and surgery had neither anesthetics nor antiseptics to aid in their successful work.

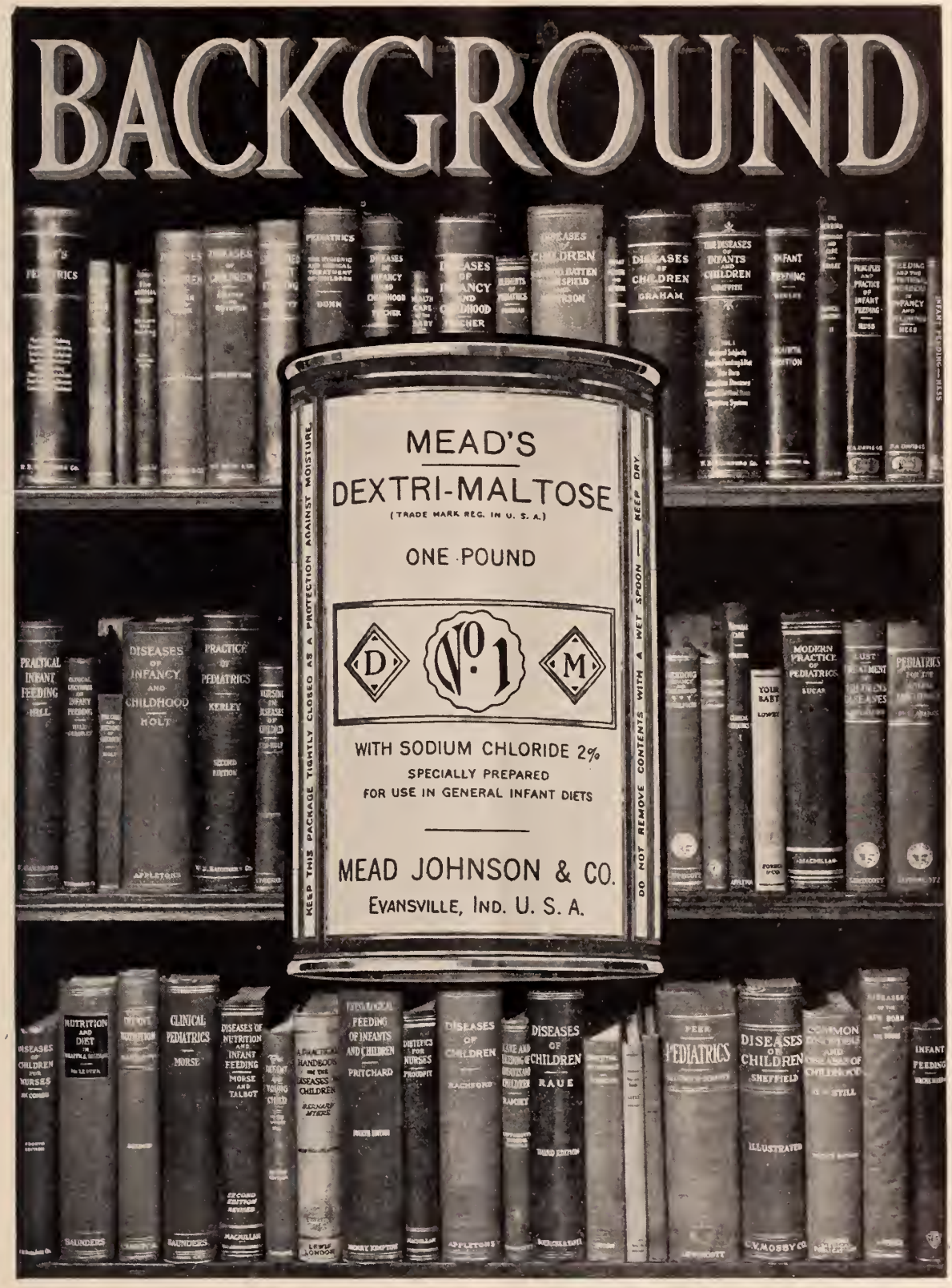
I am going to speak most of the time about something else, but I want to say first that I am in the fullest accord with everything that Doctor Moffitt has said. . . .

Dr. A. A. D'Ancona: The development of medicine and of medical education in California is illustrated by the appearance of President Jordan here tonight. I remember some years ago, when our medical school was merely allied to the University, I met a regent one day—Arthur Rodgers, now dead—who took pride in the statement that the Board of Regents had kept faith with the medical faculty and had never interfered in any medical affairs. . . .

Dr. R. L. Wilbur: I took it for granted that between Doctor Moffitt and President Jordan all of the essential features would be taken up, and now that Doctor D'Ancona has presented the more idealistic point of view there is very little left for me to say. It interested me very much to hear that Doctor Moffitt has come to believe that such a department as that of internal medicine must, in the University Medical School, be controlled by individuals who devote all their time to the development of medical teaching and research. . . .

Dr. D'Arcy Power: The only value of anything I can say is perhaps dependent upon the fact that for a long time I have had a reasonable opportunity of watching a large number of men who have been trained in the different medical schools and who have sought to pass our State Board examinations. Thus I know fairly well the ways in which medical education has failed. It is by noting the failures that we can make something like provision for better conditions in the future. It has been my privilege in the last three years to know fairly well the mental make-up and

(Continued on Page 22)



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

educational equipment of something like two hundred men from all kinds of colleges, from the worst to the best. Certain facts have come out so clearly that I am convinced that they are of primary importance.

Dr. Richard C. Cabot, Boston: The question is, I believe, of the rightful relation of an academic clinic to the medical profession and to the general public.

In the first place, what can the clinic do for the doctor? . . .

From an Article on "Treatment of Spiral Fractures of the Tibia" by Charles G. Levison, M. D., San Francisco.—The object of this paper is to lay down specific rules for the treatment of spiral fractures of the lower third of the tibia. The subject is of great importance, for the condition is one of the most difficult to treat in the category of fractures. . . .

From an Article on "A Physician's Vacation" by Douglass W. Montgomery, M. D., San Francisco.—It was urged recently in an editorial in this JOURNAL that every physician should take a holiday, else he might become a "stale" doctor: A stale medical man in these aseptic and bustling times would be a grave misfortune, especially to the "stale" one. Shortly before the appearance of the aforesaid editorial I, with my wife and daughter, went on a health-seeking expedition into the Sierra Nevadas, and behold some of the experiences that we underwent there. . . .

From an Article on "Acute Poliomyelitis in California" by F. F. Gundrum, M. D., Sacramento.—In a previous paper it was shown that acute poliomyelitis has been occurring in California for many years, both as sporadic cases and in occasional epidemics. These epidemics have been usually small, but within the past few years the numbers attacked have greatly increased. No further authentic ac-



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counts have been obtained of past outbreaks except one group of two cases near Bodega Bay, Marin County, in April, 1888. It is the purpose of this communication to record the history of poliomyelitis in California during the past three years.

From an Article on "Impressions" by H. J. Kreutzmann, M. D., San Francisco.—The practice of medicine is certainly interesting and fascinating for many reasons; to myself the fact that we in our daily work can make the most interesting scientific observations and researches has always been especially attractive.

On the other side, no work of any kind taxes and racks the nerves of a person more than the practice of medicine. It is not only the great responsibility of our decisions, often involving life and death, health and happiness, which makes our position difficult; but what has always appealed most to me is the fact that in our daily work we are made not merely witnesses, but active participants, in the greatest tragedies of life. When priest or undertaker steps in, death has done its work, they stand before an accomplished fact; but we physicians are right in the battle line for life; we, if we have any heart at all, cannot entirely escape the anxiety, worry, disappointment and despair so often accompanying the struggle for life. . . .

From an Article on "Psychiatric Duties of Large Cities." The discussion brought out by this paper (which was read before the San Francisco County Medical Society in March and was printed in the April JOURNAL) seems to be sufficiently interesting and valuable to warrant its publication. It was not received in time to be printed with the paper, an early publication of which was urgently requested by the San Francisco Society.

Dr. W. F. Snow read the following letter from Dr. F. W. Hatch, who was unable to be present:

"It is evident that existing state hospitals do not fully answer the needs of the insane, owing to their distance from the centers of population and compulsory commitments. It is also apparent that existing measures for the care of the insane, previous to commitment, are not generally satisfactory and that neither the state hospital nor the quarters for the preliminary care of the insane afford the medical schools nor the medical profession the opportunities for the study of mental diseases that they should have.

"The state hospitals with their receiving and treatment buildings are doing advanced work in the care and treatment of acute cases, but this usefulness is limited by the necessity of legal commitment before their advantages and aid could be obtained. . . ."

From Railway Surgeons:

Report of a Case of Sarcomatosis by J. H. O'Connor, M. D., and W. T. Cummins, M. D., San Francisco.—History: Mr. C. H., aged 49, an engineman, was admitted to the Southern Pacific General Hospital on September 23, 1911. His father and mother died of pneumonia. Patient stated that his habits were temperate, and that he had had gonorrhea, but denied luetic infection. No other diseases were elicited. Present condition began three years before with a slight swelling in the left supraclavicular region. This gradually increased in size without pain or loss of weight.

Examination: Patient appeared well nourished. Pulse and respiration normal. No fever. Tongue clean. Thorax and abdomen negative. In the left supraclavicular region there was a firm, movable mass about the size of a hen's egg. Other superficial lymph nodes not palpable. . . .

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(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

From Association News:

Membership in the American Medical Association—The Proposed Change in Name—George H. Simmons, M. D., LL. D., Chicago.—The American Medical Association always has been a delegated body; only "delegates" ever had a right to take part in its proceedings. . . .

* * *

Membership in the American Medical Association: Today on the Same Basis as the Former "Members by Application."—Briefly, we have the following situation:

1. The voting membership of the organization is the combined membership of all the 2,000 (more or less) component county societies, amounting approximately to 70,000 members. These elect the delegates to the House of Delegates of the state associations; they in turn elect the delegates who form the House of Delegates of the American Medical Association. Before 1901 the delegates to the American Medical Association were elected, or appointed by the "affiliated" societies, which included local, district, and state societies.

From Some News Notes Taken from Newspapers:

The Long Beach Physicians' Club entertained Dr. Harvey W. Wiley when he was out this way on a lecturing tour.

* * *

Fresno is going to make a great effort to compel all dog owners to muzzle their pets this summer and put a stop to rabies.

* * *

Meningitis, of the acute epidemic type, has appeared in the vicinity of Bakersfield and also in the Sacramento Valley, though not a very large number of cases have as yet been noted.

The nurses of the state have been actively campaigning against the "eight-hour bill" as it applies to nurses, and for a bill to examine and register nurses and permit those registered to use the letters "R. N."

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 392)

Reports indicate that Carlyle A. Klein was arrested in Los Angeles, February 4, 1938, assertedly falsely claiming medical credentials. He is said to have associated himself with a licensed physician and surgeon in "a clinic at 4622 Wilshire Boulevard." Assertedly charged with forgery and issuing checks without sufficient funds, Klein failed to appear for trial in Los Angeles Superior Court, April 7, whereupon bail of $500 was forfeited and a bench warrant issued.

John Grusd, said to be a licensed chiropractor, was on February 24, 1938, found guilty of violation of the Business and Professions Code, arising out of his alleged practice of obstetrics, and was reported to have been sentenced to be confined in the county jail for five days, which sentence was suspended and he was placed on probation for a period of one year, on condition that he refrain from practicing obstetrics.

Reports indicate that Edward John Jones, reported former San Quentin inmate, and said to have purloined instruments from various hospitals where he worked as intern and orderly, was investigated by the Texas police recently. "As evidence of his qualifications, Jones presented a 'diploma,' attesting to his graduation from the 'United States Naval Pharmacistic (sic) Mates School of Medicine, Portsmouth, Virginia.'" He acknowledged having this diploma made by a printer in Oklahoma City.

(Continued on Page 26)





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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

Reports of the Investigation Department indicate that on March 25 C. Young, alias Wong Yee, Chinese herbalist, was arrested in Pittsburg, California, on a charge of violation of the Business and Professions Code. On March 30 he pleaded guilty and was sentenced to sixty days in jail, suspended on condition that he refrain from further violation of the Business and Professions Code.

Investigation records indicate that on March 16 Charles Joseph Kribs, alias Dr. J. B. Kurtz, pleaded guilty in Los Angeles to a charge of violation of the Business and Professions Code, relating to the practice of medicine, and was sentenced to 180 days in the county jail, which was suspended. He is also reported to have been sentenced to serve 180 days for violation of the optometry provisions of the Business and Professions Code and committed to jail. "Two petty theft charges against this defendant were dismissed."

Arthur William Nord, on March 16, was reported sentenced in Bell, California, to serve ninety days in the county jail on a charge of violation of the Business and Professions Code and was committed.

"Dr. E. Blanche Ramer, San Diego physician, was convicted of performing an illegal operation by a Superior Court last night in Judge Arthur L. Mundo's Court." (San Diego Union, March 4, 1938.) (Previous entries, December, 1937; March, 1938.)

"Outright probation was today granted Dr. E. Blanche Ramer, fifty-one, prominent woman physician, who last month was found guilty of having performed an illegal

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operation. . . . Superior Judge Arthur L. Mundo placed Doctor Ramer on probation for five years. . . . Her probation term prohibits her from practicing medicine. . . ." (San Diego *Tribune*, March 26, 1938.)

Records indicate that on March 28, 1938, a San Diego Superior Court dismissed the matter of E. Blanche Ramer vs. Board of Medical Examiners, wherein was sought to set aside the revocation of Blanche Ramer's license by the Board of Medical Examiners.

"Mrs. Ann Brown, alias Jane Wright, was arrested at 1304 Fillmore Street yesterday on a charge of having performed an illegal operation upon Mrs. Dorothy Marks, twenty-five, Oakland stenographer. The woman, police say, has a record of arrests in 1927 and 1937. . . ." (San Francisco *Chronicle*, March 14, 1938.)

"Dr. L. J. Giubbini, licensed chiropractor, and Marvin Raithel, once implicated in coast-wide illegal operation rings, were indicted by the Federal Grand Jury yesterday on charges of failure to file income tax returns in 1934 and 1935 and conspiracy to evade payments. Doctor Giubbini operated a bacteriological laboratory in San Jose. Raithel was indicted in Los Angeles last November as a member of an illegal ring, but the case was dismissed when he testified against others indicted." (San Francisco *Chronicle*, March 12, 1938.) (Previous entries, July, August, and September, 1936.) (Annual Report, 1936, Board of Medical Examiners.)

"Dr. Hjalmar Groneman, chiropractor, yesterday became $28,500 richer by a Superior Court order giving him half the estate of the woman he was once accused of slaying. An order was signed by Judge John J. Allen in Alameda County Superior Court and terminated litigation started by three relatives of Ella Mae Clemmons, 'Christ Angel of Chinatown.' . . ." (San Francisco *Chronicle*, March 11, 1938.) (Previous entries, September, 1932; March, 1936; February, 1937.)

"Lawrence P. Lorraine, forty-five, a male nurse of 2764 Riverside Boulevard, today was taken into custody under a grand jury indictment charging him with performing an illegal operation. He was placed in the county jail under $10,000 bail, set by Superior Judge Dal M. Lemon. Lorraine has faced similar charges twice previously. Last time, in 1935, he was acquitted after a trial prosecuted by the Attorney-General's office." (Sacramento *Bee*, March 15, 1938.) (Previous entries, January, February, 1935.)

" 'Dr.' Howard C. Woodward, thirty, will not be 'practicing' for thirty days at least. That was the jail sentence given him today by Police Judge Joseph A. Kennedy on a battery charge preferred by Mrs. Annie Morris, 3125 Elm Street. According to Police Inspectors L. M. Jewell and Thomas Duffy, Woodward has been posing as the son of Dr. B. W. Black, Alameda County Medical Directory. In this capacity inspectors say Woodward called on women, gave them physical examinations and instructed them in exercises purported to cure certain ailments. Oakland police have been looking for him about six months, but it was Woodward's own flair for publicity that led to his capture last Friday. Last Tuesday he broke into public print by offering an eye to the Rev. U. E. Harding, blind pastor of Portland, Oregon, who visited Oakland in search of a cornea section from a dead man's eye, to be transplanted to his own eye, in the hope of regaining his sight. The Reverend Harding declined Woodward's offer, but the story appeared and the police got on the trail. At that time Woodward said he was an unemployed cook. Police records show that Woodward once served a term in San Quentin Prison for forgery." (Oakland *Tribune*, March 19, 1937.)

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"A suspected drug addict, who reportedly stole eight medical bags from Santa Ana and Orange doctors up to yesterday, has two more thefts charged against him, Santa Ana and Orange police reported today. The bags were taken from automobiles." (Santa Ana *Register*, March 30, 1938.)

"At the request of the State Medical Board, the Attorney-General will appeal to the Appellate Court in an effort to set aside Judge A. R. Cotton's decision, granting Dr. Paul Eid, young Burlingame physician, a new trial on lewd conduct charges, it was learned today. . . . Doctor Eid, sentenced to the county jail, pleaded guilty in the lower court, but later claimed that he was 'framed.'" (Redwood City *Tribune*, April 1, 1938.) (Previous entry, December, 1937.)

"Episcopal funeral rites for Homer J. Castellaw, forty-eight, attorney, who died on Sunday at Saint Vincent's Hospital, will be held tomorrow. . . . For ten years Mr. Castellaw was attorney for the State Medical Board. . . ." (Hollywood *Citizen News*, April 5, 1938.)

"Evidence presented yesterday to support charges against a woman who practiced medicine without a license, so aroused Municipal Judge Frank W. Dunn that he suggested further prosecution. The defendant, Jean Adams, forty-two, of 2511 Sacramento Street, pleaded guilty on two counts, following the testimony from Donna McEachern, twenty-five. The girl said she went to the Adams woman in the belief she was a doctor, paid her $450 for some two hundred treatments for a disease which the Board of Health physician said she never had. . . . 'This defendant is a

(Continued on Page 30)

Symptomatic control of Hay Fever and Asthma, with minimum toxic manifestations



Propadrine Hydrochloride is indicated in the control of allergic manifestations. It possesses pharmacologic effects similar to those of ephedrine, but seldom produces the undesirable side-effects of insomnia, nervousness, excitation or nausea which may accompany the administration of ephedrine. Thus, it usually obviates the necessity of simultaneously administering sedatives.

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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

menace,' said Judge Dunn. 'I suggest that additional charges be filed if evidence warrants it, and if she is convicted I will make the sentences consecutive." (San Francisco *Examiner*, April 7, 1938.)

"Seven physicians and one attorney, convicted recently of conspiracy to violate the ambulance-chasing laws, were placed on probation today with heavy fines and provisional county-jail sentences, by Superior Judge Frank M. Smith. . . . Dr. G. O. McKeehan was given one of the heaviest penalties when he was ordered to pay $500 and spend one year in jail on a five-year probationary period. . . . Dr. W. B. Humphrey was placed on three years' probation, ordered to pay a $300 fine and to serve thirty days in jail. Similar sentences were meted out to Drs. A. L. Wallace, C. D. Fredericks, and Albert E. Liddell. Dr. M. C. Cooley was placed on five years' probation and ordered to serve one year and pay a $500 fine. All were convicted of conspiring with George O. Dorris, confessed asserted 'brains' of the ring, in a combine to further the filing of civil damage suits in accident cases. . . ." (Pasadena *Star News*, March 31, 1938.) (Previous entries, June, 1936; September, 1937.)

"Dr. Max Hickok (licensed chiropractor), convicted of second degree murder last November as a result of the abortion death of Mrs. Elizabeth Sowers of Oakland, sued the City and County of San Francisco yesterday for return of chiropractic apparatus and office equipment confiscated by the police department." (San Francisco *Recorder*, March 31, 1938.) The Board of Chiropractic Examiners report the issuance of Doctor Hickok's 1937 annual registration, assertedly based upon advice from the Attorney-General that renewal fee should be accepted, pending appeal of Doctor Hickok's conviction.

Authorities say: The value of Vichy Celestins as an adjuvant in hepatic and gastric affections, has long been acknowledged in medical literature. Its use is indicated both in their treatment and dietetic management.

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Present-Day Status of Vitamins.—With a gradual acceleration of knowledge beginning less than a half-century ago, the whole subject of vitamins with its vast ramifications has been built up by means of chemical, biologic, and clinical studies, until it has practically attained the status of an exact science. Booth and Hansen point out that not only is the chemical structure of many vitamins known exactly, but recent investigators have developed chemical tests for determining quantitatively the amounts of various vitamins in the different tissues. Further developments along these lines may prove to be of far-reaching importance. Of greater importance than the presence of florid avitaminosis is the occurrence of subclinical states of vitamin deficiency. This is particularly significant because of the interrelationships between vitamins and certain clinical disorders. The fact that knowledge concerning the nature of these deficiency diseases has advanced so definitely necessitates a more specific nomenclature regarding these conditions. Their review includes a history of all the vitamins, their standardization, the resultant pathologic changes when their individual ingestion is lacking or deficient, the chief symptoms and laboratory diagnosis of the respective avitaminosis, their clinical application, daily requirements, and their natural sources.—*Journal-Lancet, Minneapolis.*

Maurice Chevassu Elected President of Académie de Chirurgie.—Prof. Maurice Chevassu, whose clinic at the Hôpital Cochin has been visited by many American urologists, was elected president of the Académie de Chirurgie of Paris for 1938. Professor Chevassu will succeed Professor Marion as head of the urologic department of the Paris Medical School in the fall of 1938.



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HOWARD MORROW, M.D.
President, California Medical Association
1938

CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 48 MAY, 1938 NO. 5

SALUTATION FROM PRESIDENT MORROW

To Members of the California Medical Association—

Greetings:

I salute you in the name of our profession and extend to you a very cordial invitation to attend the sixty-seventh annual session of your Association in Pasadena, May 9 to 12.

Our annual session affords the opportunity for every member to acquire information upon medical progress by hearing the presentations and discussions of competent clinicians and teachers. In addition, there are the inspiration and pleasure of meeting one's friends, forming new acquaintances, and engaging in the scheduled social functions. The personal benefits received more than compensate for the time spent in attending. A careful reading of the announcements, therefore, should induce you to plan to be present, and I sincerely trust that you will come.

At this time, I desire to officially extend expressions of appreciation to the section officers and speakers for their labor and contribution of time in preparing and taking part in the scheduled program. The success, the benefits, and the good that attend this session will be largely due to their efforts. We are grateful for their services and coöperation.

Lastly, may I emphasize anew that your membership affiliation is one of your most valuable possessions. Your loyalty to your county and state medical organizations will materially enhance the results accruing to you as a member. I bespeak your continued interest and sustained support, to the end that our Association and its constituent units may meet the problems of the times, and formulate well considered and directed solutions that will greatly help to secure public confidence and good will. We can lead, instead of being led.

Cordially,

HOWARD MORROW.

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above; advertising and business communications to Secretary-Treasurer, Dr. Frederick C. Warnshuis, also at above address.

EDITOR GEORGE H. KRESS

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BUSINESS MANAGER . FREDERICK C. WARNSHUIS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

LOS ANGELES CONGRESSMAN WOULD INVESTIGATE THE AMERICAN MEDICAL ASSOCIATION

California Newspapers Announce Another Possible Survey from Washington.—As stated in press dispatches from Washington to the *Los Angeles Times*, under date of April 10, Hon. Byron N. Scott of Long Beach, representing the Eighteenth Congressional District, introduced a resolution in Congress "calling for an investigation of American Medical Association opposition to group medicine." "He asked" (so the correspondent averred) "that a committee of five be appointed to investigate the local dispute [between the District of Columbia Medical Society; Home Owners Loan Corporation;* Group Health Association], and to cover the campaigns of the American Medical Association against group health organizations throughout the country." Comment of similar nature appeared in the Long Beach *Press-Telegram* of April 9, which quoted Congressman Scott concerning medical society activities in San Diego and San Francisco.

* * *

California Medical Association Members Should Read Congressman Scott's Resolution. We are able to print a copy of Congressman Scott's resolution, and suggest that all members take the time to read and study it—both its lines and between the lines. The language which this California Congressman used in framing his resolution does not indicate an impartial approach to the matters he would have the House Committee study; and, taking into account the powers it is proposed to rest in such a committee, as given in the last paragraph of the resolution, it is not difficult to forecast the kind of report that might be elaborated.

However, whether Congressman Scott of Long Beach will be able to persuade the House Rules Committee to place his resolution on the floor during the present session is not known, although the newspapers state that "he will seek a hearing before the House Rules Committee."

* * *

Implied Insinuations and Prejudgments.—It is hardly necessary to add that members of the California Medical Association take little stock in some of the insinuations and criticisms implied in Congressman Scott's resolution. The governing bodies of the California Medical Association and county medical societies in California know how little real warrant there is for an attitude and point of view such as that to which the Representative from the Eighteenth District has consciously or unconsciously given expression, and the same thought must come to the members of the compo-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* For items concerning this, see CALIFORNIA AND WESTERN MEDICINE, as follows: December, 1937, on page 433; January, 1938, on page 4; February, 1938, on pages 149 and 150.

nent county societies that make up the several constituent state medical organizations forming, collectively, our parent body, the federacy known as the American Medical Association.

* * *

Congressman Scott and the Metropolitan Water District.—In another investigation which Congressman Scott has taken up, concerning the Metropolitan Water District (which includes the cities and communities in Southern California that will bring the Colorado River water to the southern section of the State), the Los Angeles *Evening Herald-Express* of April 15 stated, among other things, in a prominently displayed article:

Charging Congressman Scott with prejudging the issues involved in the strike, the Board's reply pointed out that the Congressman, before he had given district officials an opportunity to answer his questions, proceeded, in the same letter, to accuse the district of not practicing collective bargaining.

Here is additional evidence that in Congressman Scott we have a member of the House of Representatives with a penchant for "prejudging issues." In any event, by these somewhat erratic activities, members of the medical profession in California are warranted in watching the career of the Hon. Byron N. Scott, who formerly taught school in Long Beach and who now, as a congressman, is engaged in tasks of quite a different nature.

* * *

Text of Congressman Scott's Resolution.*—This singular resolution, calling for congressional investigation by a committee "(1) to inquire into the activities of the American Medical Association, state and county medical societies"—(a provision broad enough to include, also, the California Medical Association and its many component county societies)—follows:

(COPY)

SEVENTY-FIFTH CONGRESS, THIRD SESSION

HOUSE RESOLUTION 452

In the House of Representatives, March 28, 1938

Mr. Scott submitted the following resolution, which was referred to the Committee on Rules and ordered to be printed:

RESOLUTION

WHEREAS, Group hospitalization and medical care on a periodical prepayment basis are successfully rendering valuable services throughout the United States; and

WHEREAS, The American Medical Association, various state and county medical societies, and the Medical Society of the District of Columbia have been actively opposing the plan and operation of Group Health Association, Incorporated, and other similar groups organized as voluntary, nonprofit associations for the purpose of protecting the health of their members; and

WHEREAS, It has been charged that such opposition by the Medical Society of the District of Columbia has recently jeopardized the health and even endangered the life of one or more employees of Federal agencies who are members of Group Health Association; and

WHEREAS, Members, officers, and employees of the American Medical Association and its affiliates, in correspondence, published articles, and statements, have misrepresented the activities, contractual relations, and policies of Group Health Association, Incorporated, with regard to its members, their physicians, and the public in a seemingly deliberate attempt to injure and destroy this association; and

WHEREAS, The Medical Society of the District of Columbia has directed its members to refuse to enter into consultation with physicians employed by members of Group Health Association for the purpose of treating or advising Federal employees and their dependents who are members of such association, even though the physicians employed by the association are duly licensed to practice medicine in the District of Columbia; and

WHEREAS, It has been charged that certain hospitals in the District of Columbia have denied the use of their facilities to duly qualified physicians employed by members of Group Health Association, not upon the ground of lack of professional qualifications but for the reasons that such physicians are not members of the Medical Society of the District of Columbia or are employed by a group not approved by said society; and

WHEREAS, Charges have also been made that certain hospitals in the District of Columbia have denied admission to persons, members of Group Health Association, for medical and surgical treatment by physicians of their own choosing, duly qualified and licensed, simply upon the ground that such physicians are not members of the Medical Society of the District of Columbia or are employed by a group not recognized by said society; and

WHEREAS, While a certain physician employed by members of Group Health Association has been expelled by the Medical Society of the District of Columbia from membership in said society upon the ground that he is engaged in the practice of medicine for members of Group Health Association, other members of said society in good standing are permitted to engage in the contract practice of medicine with similar groups without question, all of which indicates that said society, by reason of prejudice and hostility against Group Health Association, is unjustly and possibly unlawfully discriminating against highly qualified, reputable, and duly licensed physicians employed by members of Group Health Association; and

WHEREAS, The American Medical Association and its affiliates, local medical societies throughout the United States, are taking action to exclude or expel from membership in such societies licensed and reputable physicians who have become professionally associated with coöperative groups; and

WHEREAS, If such matters be true, the American Medical Association, its affiliates, and particularly the Medical Society of the District of Columbia are acting in contravention of their charters, in violation of law and contrary to medical ethics and sound public policy; and

WHEREAS, A preliminary study of the situation indicates that, through the prejudice and hostility of responsible groups within the American Medical Association, its affiliates, and the Medical Society of the District of Columbia, interference with reasonable competition among physicians in the United States is occasioned, and indicates that the free choice of physicians by patients in need of medical care and attention is being denied, a situation which jeopardizes the life and health, well-being, and general welfare of the public throughout the United States and the District of Columbia; therefore be it

Resolved, That the Speaker appoint a select committee of five members of the House and that such committee be authorized and directed (1) to inquire into the activities of the American Medical Association, state and county medical societies, the Medical Society of the District of Columbia, and of their officers and members against members of the medical profession, Group Health Association, Incorporated, and other coöperative or contractual groups using the services of hospitals and physicians; (2) to deter-

* Editor's Note.—While these editorial comments were in the hands of the printer, we received a copy of the *Bulletin of the San Diego County Medical Society* in which was given an article that appeared in the April 5 issue of a Washington, D. C., publication, *Labor*.

The information contained therein should be of interest to all members of the medical profession, and the item is printed in this issue of CALIFORNIA AND WESTERN MEDICINE, in its Special Articles department, on page 382. You are urged to read it.

mine whether the American Medical Association, its affiliates, the Medical Society of the District of Columbia, or any of them, are engaged in activities prejudicial and detrimental to the health, life, well-being, and general welfare of the public throughout the United States and the District of Columbia; (3) to ascertain whether the activities of such organizations against Group Health Association, Incorporated, or other groups having similar objectives and physicians employed in behalf of such groups, are in violation of law, in contravention of their charters, or contrary to medical ethics and sound public policy; and (4) to report to the House the results of its investigation, together with such recommendations as it deems advisable.

For the purposes of such investigation the committee, or any subcommittee thereof, is authorized to sit and act during the present Congress at such times and places, whether or not the House is in session, has recessed, or has adjourned; to hold such hearings; to require the attendance of such witnesses by subpoena and the production of such books, papers, and documents by subpoena *duces tecum*; and to take such testimony as it deems necessary. Subpoenas shall be issued under signature of the chairman of the committee or any member thereof designated by him and shall be served by any person designated by such chairman or member.

RABIES IN CALIFORNIA

Rabies in England and in California.—England is practically free of rabies. Its measures on the importation of dogs, designed to prevent the introduction of rabies into the United Kingdom, are strictly enforced. By contrast, in California, and more particularly in the southern part of the state, especially in Los Angeles County, the incidence of rabies, not only as a disease of animals, but of human beings, is astonishingly large. During the past year, several deaths of persons who were victims of rabid animals have been recorded in Los Angeles alone, a matter of more than tragic interest since all the particular victims of dog bites were unfortunate enough not to have taken the Pasteur treatment.

Rabies first appeared in California in 1899, and in the past thirty-eight years more than twice that number of persons—eighty-six in all—have died from the disease.

* * *

Incidence of Rabies in Some California Counties.—As regards rabies in dogs, Los Angeles leads the counties in the state with its record, during the past fifteen years, of 9,377 proved cases. Some of the other counties present the following figures: San Diego County, 643 cases; San Bernardino County, 277 cases; Imperial County, 244 cases; San Joaquin County, 253 cases; and Fresno County, 226 cases. Alameda County is credited with 125 cases, but, much to its credit, San Francisco has had only five cases.

The above statistics show that the disease is well established in the southern part of California, and that it is traveling northward.

* * *

Rabies Among Animals Other Than Dogs.—Not only dogs, but other animals contract and communicate the disease, and it may be of interest to note that just at the time of this writing we are in receipt of a memorandum from the State Board of Public Health giving the following interesting information:

Human death from rabies, Kings County, reported on April 9, 1938. Man was bitten by cow three weeks ago; started treatment, and died.

Cow's head was sent to Stanford University, and positive laboratory findings were reported on April 9, 1938.

In California, during the past fifteen years, rabies has been demonstrated in a total of 821 lower animals, other than dogs, and of such instances a total of 319 were cows. The human case, above recorded, proves that even from such bovine and other animals there is danger.

* * *

State Board of Public Health Has Declared Quarantines.—Recently the State Board of Public Health declared dog quarantines in Los Angeles City and Los Angeles County territories, and in Ventura County also. Concerning the California rabies quarantine laws (Section 2, Chapter 369, Statutes of 1913), the State Board, in its initial promulgations, has no latitude, the Act making it necessary to place all dogs and cats under quarantine restraint on the premises of owners. Fortunately, the statute permits the Health Board, in its judgment (as warranted by investigation or later information), to modify these stringent provisions. Thus, since only 256 cats have been shown to have had rabies in California during the past fifteen years, the modified quarantines exempt that animal, but make it necessary that all dogs be confined on the premises of owners, with provision that they may be taken off the same, by persons over the age of fifteen, when led on leash.

* * *

Large Stray Dog Population of Los Angeles Is a Public Health Menace.—Los Angeles City is credited with an unlicensed stray dog population of 20,000 animals! It is, therefore, understandable why Los Angeles County should lead other counties in the state as regards the prevalence of animal rabies (more than 1,700 proved cases of rabies in dogs during the past year), and this, not by hundreds, but by thousands of cases.

* * *

Improper Use of Dog License Fees in Los Angeles a Factor in the Incidence of Rabies in That County.—It is also of interest to know that Los Angeles City, during the past twenty years, has transferred about one million dollars from its dog license incomes to its general fund, for use on streets and other purposes! However, during the past year, the three human deaths reported from that metropolitan center, with all the resultant adverse publicity, may lead the city councilmen and organizations such as the Chamber of Commerce to pay more attention to this public health problem, and induce the city fathers to spend such money received from dog owners in more carefully planned and continuous efforts to stamp out rabies in Los Angeles. The matter is quite as important as good streets, both to the general public and especially to citizens so unfortunate as to contract this dread disease, rabies.*

* See CALIFORNIA AND WESTERN MEDICINE, April issue, on page 259, for other comments concerning rabies. Also in this issue, on page 391.

Every County Medical Society Should Be Interested in This Public Health Problem.—To this problem, the Los Angeles County Medical Association, through formal resolutions, some time ago called the attention of the Board of Supervisors, the City Council and the Chamber of Commerce; and, as a consequence, the health officers are now being given active support in their efforts to pick up the stray animals. The critical situation is one that is worthy of the attention of all health officers and county medical societies, not only in the southern, but in other parts of the state. Only by united, conjoint effort will it be possible to eradicate this distressing disease at this late day, and so prevent the spread of rabies to all parts of California and Pacific Slope states.†

ANNUAL PRINTED REPORTS OF COUNTY HOSPITALS

Original Purpose of County Hospitals.—County hospitals in California are institutions which originally were brought into being in order to provide hospitalization and medical care for indigent citizens who were sick or injured, such service being rendered without cost; because, as "indigent" citizens, the patients were practically "bankrupt" citizens. In the last several years, under the stress of adverse economic conditions prevalent here and throughout the Union, the stipulations for admission have been broadened to include "medically indigent" citizens; that is, to include a group also called "partly indigent" citizens, who, after providing themselves and their dependents with roof coverage, clothing and food, are not in possession of additional financial resources adequate to meet the hospitalization expenses of unforeseen sickness and injury. For such "partly indigent" or "medically indigent" citizens, it has been specified recently that "in proportion to their means," they shall repay to the counties a fair proportion of the cost of their care.‡

* * *

Attending Staffs Whose Members Give Gratuitous Professional Service.—In most of the county hospitals of California, members of the medical profession of the respective communities, acting jointly as attending staffs, give gratuitous service to patients. In the large Los Angeles County Hospital, for instance, with its more than 2,600 bed patients, the attending staff consists of more than 500 physicians, surgeons and specialists, nearly all of whom are members of the Los Angeles County Medical Association. It has been calculated that a conservative estimate of the money value of the professional services thus rendered by that group of physicians is in excess of two million dollars annually, a handsome sum, certainly, to donate to the taxpayers of Los Angeles County!

Gratuitous Service Has Never Been Recognized Through Printed Annual Reports.—In spite of this generous gift of services, the pecuniary value of which has only recently been emphasized, the County of Los Angeles has never deemed the work done by these members of the medical profession as warranting the expense of a printed report! Year after year the medical board of the staff has passed resolutions asking for such a report; but, up to the present time, these requests have seemingly been lost or otherwise nullified somewhere en route to the Board of Supervisors—which latter body, in compliance with law, must specify all expenditures in its annual budget. Through all these years the report of the Medical Director of the Los Angeles County Hospital on the professional activities of the institution's staff has consisted of some unbound mimeographed sheets containing limited information of far less amount and character than that which for years has been annually brought out by hospitals throughout the United States, many of these remoter institutions being of far lesser size and resources.

* * *

Reports of a Salaried County Department.—By contrast, the annual report of the Health Department of Los Angeles County for the year ending June 30, 1937, is a neatly bound volume of 115 mimeographed pages, although that department portrays therein only the activities of *salaried employees*. Which emphasizes, perhaps, the uncomplimentary fact that nonsalaried physicians are just foolish enough to expect such a public presentation as a proper report of their gratuitous professional services!

* * *

A Contrary Example: The Printed Report of The Queen's Hospital of Honolulu.—In this issue of California and Western Medicine is given a letter from the former assistant superintendent of the Los Angeles County Hospital, who is now superintendent of The Queen's Hospital in Honolulu. He sent us a copy of the seventy-eighth annual report of that institution, a book of sixty-two pages, and called attention to the fact that even in these recent years of depression The Queen's Hospital has published annually its report on the year's activities.

* * *

A Printed Report on Los Angeles County Hospital Has Been Promised.—At a recent conference with the chairman of the Board of Supervisors of Los Angeles County, when his attention was called to the need of such a printed report, and the treatment accorded to former requests, he assured us the desired provision would be made in this year's budget. So now, it would seem that the effort kept up for years to have a yearly printed report is about to be crowned with success. Once started, then, in good time, a report really representative of the work of the attending staff may be regularly forthcoming in future years.

† For comments concerning the incidence of "Rabies in Wild Animals in California," see in this issue, article in back advertising section, page 35.

‡ See California and Western Medicine, February, 1938, on page 108, for Item 8 of the Appellate Court decision in Kern County Hospital case.

Every County Hospital in California Should Print a Yearly Report.—Mention is made of this Los Angeles County Hospital experience because it is typical of what attending staffs in other county hospitals of California also face; on which account we would stress the thought: If the physicians of a county are generous enough to provide an attending staff for their county hospital, and to give to the indigent sick professional services of a value running into thousands of dollars, then the least that the boards of supervisors should do—as an expression of appreciation on the part of the taxpayers—would be to provide in their budgets (now, by the way, in the making for the next fiscal year) for printed reports on the professional work done. That, surely, is not too much to ask as a kindly return token of services willingly and generously rendered.

* * *

County Medical Societies Should Join with Attending Staffs in Petitions for Yearly Printed Reports.—If, then, every county hospital in California brought off the press, each year, such a report, the cause of the public health in California would be materially helped; because detailed reports of that nature must shed much light on methods and problems of mutual interest, especially to Californians. Every county medical society in California may well give this subject its early attention, coöperating with members who are on attending staffs in petitions requesting its boards of supervisors to place this item on their county's budget for the next fiscal year. The time, however, to act on this matter is now—while the budgets are being prepared!

CALIFORNIA MEDICAL ASSOCIATION ANNUAL SESSION: MAY 9–12

On Monday, May 9, the California Medical Association will convene at the Hotel Huntington in Pasadena to begin a series of meetings extending over four days. These meetings and conferences will mark the sixty-seventh annual session of the Association.

The April supplement of California and Western Medicine gave the complete programs of General Meetings, Scientific Sections and House of Delegates; and printed also the "Pre-Convention Bulletin," which contained the reports of officers and committees that will come up for consideration by the House of Delegates. That body meets on Monday and Wednesday evenings and members of the House should be in their seats by 8 o'clock, in order that the business may be promptly taken up.

Transportation information concerning rail, motor and local car line routes to the Hotel Huntington appeared on page 30. Members who arrive on southbound trains and who have not made other arrangements to leave the train at Glendale will probably find it much more convenient to detrain at the Southern Pacific station at Fifth and Central avenues, Los Angeles. Then, by way of street car or taxi, go to the Pacific Electric station at Sixth and Main streets, where "Pasadena via Oak Knoll" cars may be boarded. All cars on this route have a regular stop at the Hotel Huntington grounds.

A last thought: It is the hope of the officers of the Association that you will be among those who will register as "present." You are urged to attend, if only for a part of the session.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 362.

EDITORIAL COMMENT†

THE MECHANISM OF INSULIN THERAPY IN SCHIZOPHRENIA

Insulin therapy in schizophrenia promises to negate the previous markedly pessimistic outlook in dementia praecox. Yet there is almost no knowledge of the mechanisms involved. A number of theories have been suggested by Sakel himself, and by others, but little or no corroborative evidence is advanced for the different views. Because of this uncertainty, an investigation of the physiologic effects of insulin in relation to the therapeutic outcome appeals to us as being particularly pertinent.

The physiologic aspects might be classified as follows: (1) primary functions, namely, glycogen storage and increased tissue oxidation; (2) low blood sugar, with its resultant deprivation of nourishment of the brain—here might also be considered the effects of the compensatory epinephrin secretion said to occur in hypoglycemia; (3) "shock effects" from prolonged aglycemia; and (4) secondary effects from increased caloric intake, and improved intestinal absorption and assimilation, such as fat deposition. We shall concern ourselves at present chiefly with the first consideration.

Clinically, one thinks of the action of insulin largely in terms of reduction of the blood sugar, since hypoglycemia is the outstanding effect in the normal person. However, the hypoglycemia is a secondary rather than primary physiologic feature. The primary actions of insulin in the nonpathologic state are not absolutely established. Authorities state that insulin leads to the storage of glycogen in the liver and possibly in the muscles. There is some question of enhancement of oxidation in the peripheral tissues. These primary activities deplete the blood stream of its sugar. Presumably, the initial functions are not abolished when hypoglycemia is prevented by increased carbohydrate administration.

The question comes to mind as to whether or not these primary functions are significant in insulin

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

therapy: will insulin, in the absence of hypoglycemia, yield the same response as in its presence? This query has a practical implication. Treatment with the pancreatic hormone is at present very expensive and, therefore, available to a comparatively small number, and it is also not without danger. If it could be shown that the hypoglycemia is not essential, the limitations of the treatment would be removed by the simultaneous administration of insulin with glucose or food. This problem is being investigated at the present time.

One feature stressed in the literature discourages the supposition that there may be an extrahypoglycemic factor of therapeutic potency in insulin treatment. It is stated that the results are best when the hypoglycemic coma is permitted to persist from three to five hours, instead of being terminated early. The accuracy of this observation is of extreme importance, but until definitely established under controlled conditions, should not be accepted with finality. We recall that when, prior to the days of shock therapy, small doses of insulin were administered to secure weight increase in psychotic patients, favorable effects on the mental state occurred at times. May not the more potent effects of shock therapy be due to the larger dosage of insulin utilized, rather than to "shock" or prolongation of the hypoglycemia? In the investigation of the rôle of insulin in the treatment of schizophrenia, extrahypoglycemic factors are worthy of consideration.

2007 Wilshire Boulevard.

Eugene Ziskind
Esther Somerfeld Ziskind
Douglas R. Drury
Paul O. Greeley
Los Angeles.

CONVALESCENT HOMES

It is interesting to observe, after studying the problem of convalescent home facilities in Los Angeles County, that probably the chief reason why such facilities are not available, in sufficient number, is the fact that medical men are unaware of the value of such service and, consequently, have not made demands which would have produced the supply needed in their communities.

The problem of convalescent care has been very thoroughly studied by the Councils of Social Agencies in various large cities in the United States, and a similar excellent study was made by the Commission under President Hoover, which studied especially the problems of children. In all of these surveys it has been the constant opinion of the investigators that convalescent care, in a properly-equipped convalescent home, could be maintained at less than half the cost of a hospital bed. They were also consistent in finding that convalescent homes could be built for one-half the cost, per bed, compared to hospital beds.

In a period when the care of the indigent sick has been such a tremendous burden to the states and society generally, it is remarkable that more attention has not been paid to the important savings which might be made through convalescent home care. The same fact is true in the private practice of medicine. Very often a patient who does not have adequate care at home can be cared for to great advantage in the convalescent home, both from the point of view of physical and mental well-being, at much less cost than in hospital. The need for such facilities is, of course, probably more apparent to the orthopedic surgeon because of the long convalescence required in many of his cases. But the fact remains that many patients in the general practice of medicine and surgery would be much happier if they could be in a well-equipped and well-run convalescent home, rather than having to serve the long period of convalescence in the more expensive hospital bed.

A satisfactory convalescent home requires, of necessity, proper consideration of sanitation, easy mobilization of patients in case of fire, and recreation and occupation facilities, while it should have, if possible, physiotherapy available in the institution without requiring the patients' return to some outside establishment for their follow-up treatment.

The long convalescence required after fractures, especially in elderly people, is a thing which comes to mind particularly in considering what great advantage might be served by convalescent home care. These people are often very depressed by the fact of being disabled in their latter years, and the noises and outcries, which will be heard in any hospital, add greatly to the mental depression of such patients; whereas, a convalescent home, in which all the inmates have passed the point of suffering pain and where no acutely-ill person is met, either in the wards or in the recreation halls, is much more conducive to a happy frame of mind during the long months of recovery. These same months are much freer from worry if the cost to the patient can be reduced, which is, of course, the one most important thing the convalescent home can accomplish for the patient.

The ideal convalescent home would be one in which the fire hazards were so low, and the possibility of moving bed and wheelchair patients so facile that care could be given where patients were confined to bed or wheelchair by plaster of Paris or other portable fracture apparatus. This mobility permits of change of scene and a chance of recreation for patients during their confinement, and social activities for both the ambulatory and bed patient.

As medical men we should all be interested in the establishment of convalescent-home care.

Orthopaedic Hospital.

Harold E. Crowe,
Los Angeles.

"Concentration of population and the vicissitudes of modern life demand the continuous development and perpetuation of scientific medicine. We must be adequately prepared not only to render individual professional service to individual patients, but to help solve the problems of the still undiscovered causes of many diseases. In a broad sense organized society perforce depends upon us for the preservation of public health, physical virility and mental power. This then is our burden in a chaotic era of changing social philosophy."—*Cummer.*

ORIGINAL ARTICLES

SELECTIVE COLLAPSE BY PARTIAL THORACOPLASTY*

RECENT ADVANCES IN THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS

By EMILE HOLMAN, M.D.
AND
PHILIP PIERSON, M.D.
San Francisco

DISCUSSION *by Robert A. Peers, M.D., Colfax; Hans Schiffbauer, M.D., Los Angeles; F. M. Pottenger, M.D., Monrovia.*

IN the care of unilateral tuberculosis, therapeutic collapse of the lung by pneumothorax, phrenic interruption and thoracoplasty is an accepted procedure which no longer needs defense. The problem is not, shall collapse be employed, but what form of collapse is indicated. Each type, beginning with pneumothorax, will often fall short of the expected result, and when the radical thoracoplasty has finally failed, the patient is usually abandoned to the tender mercies of God and to the medical phthisiotherapist. Such failures bring the radical measures into disrepute, and yet a closer scrutiny of these unsuccessful cases will occasionally reveal the possibility that other measures, or the same measures differently performed, would have effected a cure. Particularly is this true in the cases characterized by a large apical abscess. The routine thoracoplasty will frequently fail to obliterate such an abscess, and the ultimate death of the patient is recorded as an operative failure. It may be categorically stated, however, that unless every available measure to collapse a cavity has been utilized, an unsuccessful thoracoplasty must be considered a failure, not of the underlying principle, but of the manner of its application.

* From the Departments of Surgery and Medicine, Stanford University Medical School.

Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.

RESISTANCE OF APICAL ABSCESSES TO TREATMENT

Several factors combine to make the apical abscess particularly resistant to all forms of therapy, medical and surgical. Destruction of the apical pulmonary tissue results in the formation of a "dead" space surrounded superiorly and laterally by the rigid thoracic cage and inferiorly by the floor of the abscess, which, made rigid by successive deposits of fibrous tissue, is moored to the chest wall by unyielding adhesions. Expansion of healthy lung, which is the only tissue available for filling the dead space, is impossible against this rigid floor of the abscess; and inasmuch as the lateral walls are formed by an unyielding rib cage, some external aid must be provided if the cavity is to be obliterated. In selected cases "plombiering" has had its day of vogue, but additional experiences bring less, not more, confidence in its use. Moreover, its application is limited, and usually quite inappropriate for the type of abscess under discussion. Furthermore, a foreign body remains forever "foreign," and nature attempts in every way to make its prolonged tenure within the body impossible—hence the difficulties of infection, of local extrusion, and of evacuation through a bronchus.

INADEQUATE OPERATIVE PROCEDURES

In the obliteration of such cavities the complete paravertebral thoracoplasty, now "old-fashioned," failed in a number of instances because of its tendency to displace an apical abscess downward into the paravertebral gutter. Here, protected anteriorly by overhanging stumps of the first three ribs, it continued to be a source of trouble. The obvious correction was the complete removal of the upper three ribs from transverse process in back to costal cartilage in front. This, too, proved inadequate in some instances, primarily because the cavity was protected posteriorly along the vertebral bodies by the overhanging rib stumps and transverse processes. The logical development was, therefore, a far more radical procedure, including as part of the primary collapsing procedures, resection of the

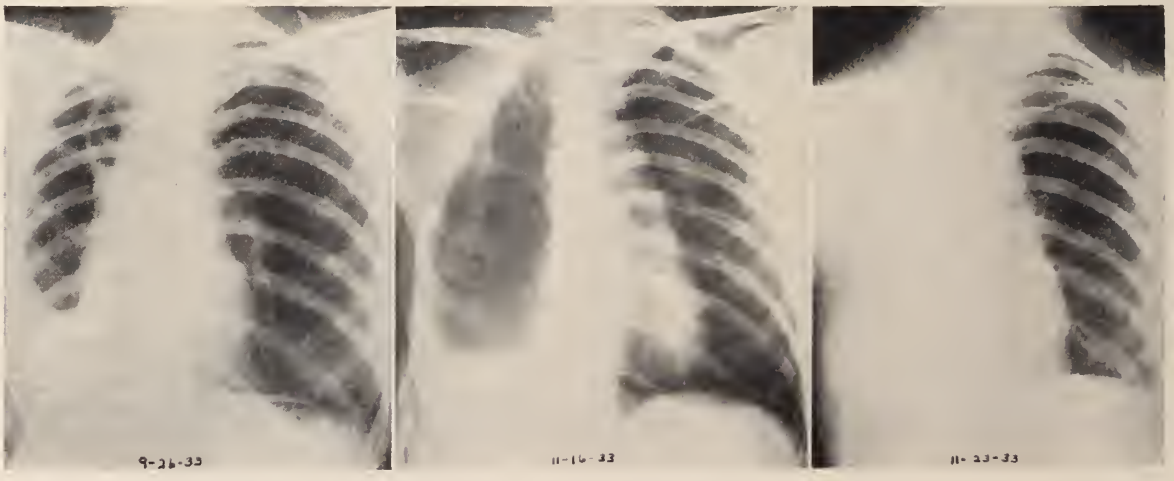


Fig. 1.—Large thick-walled abscess incompletely closed by pneumothorax, is subsequently closed by resection of eleven ribs and eight transverse processes. Patient is an arrested case.



Fig. 2.—Large thick-walled abscess closed by resection of nine ribs and of four transverse processes at the site of the abscess. Patient is well.

transverse processes of the second, third, fourth, fifth, and possibly sixth vertebrae, the number depending upon the size of the cavity. Each candidate for surgical collapse is studied with particular reference to where the apical or peripherally placed abscess will lie after the thoracoplasty has been performed. Resection of the appropriate transverse processes over a large enough area to extend well above and below the compressed abscess in its new location is carefully determined and carried out (Figs. 1 and 2). This additional procedure adds somewhat to the operative trauma; but if care is taken to divide ligaments and periosteum flush with the bony process by scalpel and sharp periosteal elevator, bleeding from injured vessels and shock from traumatized nerves are minimal.

The resection of the transverse processes is of particular importance also in the revision of an inadequate or ineffective thoracoplasty. In such a revision, it is not sufficient to repeat an operation already proved inadequate. The cause for failure should be discovered and corrected. In one instance following two complete and one partial thoracoplasty in five stages, the paravertebrally situated abscess was still well protected by the overhanging transverse processes, resection of which led to complete collapse of the cavity and a cure of the disease (Fig. 3). Fortunately, despite the five previously ineffectual thoracoplasties,

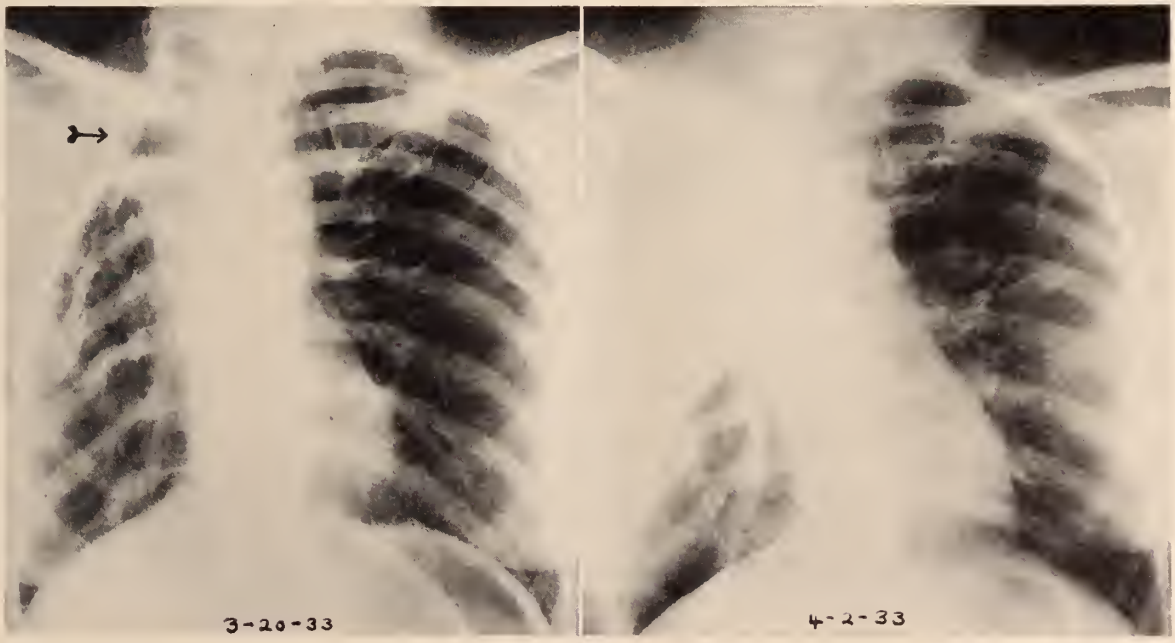


Fig. 3.—Two complete thoracoplasties and one partial thoracoplasty failed to collapse the cavity designated by arrow. This intractable focus was completely closed by resection of transverse processes and regenerated rib. Patient is well.

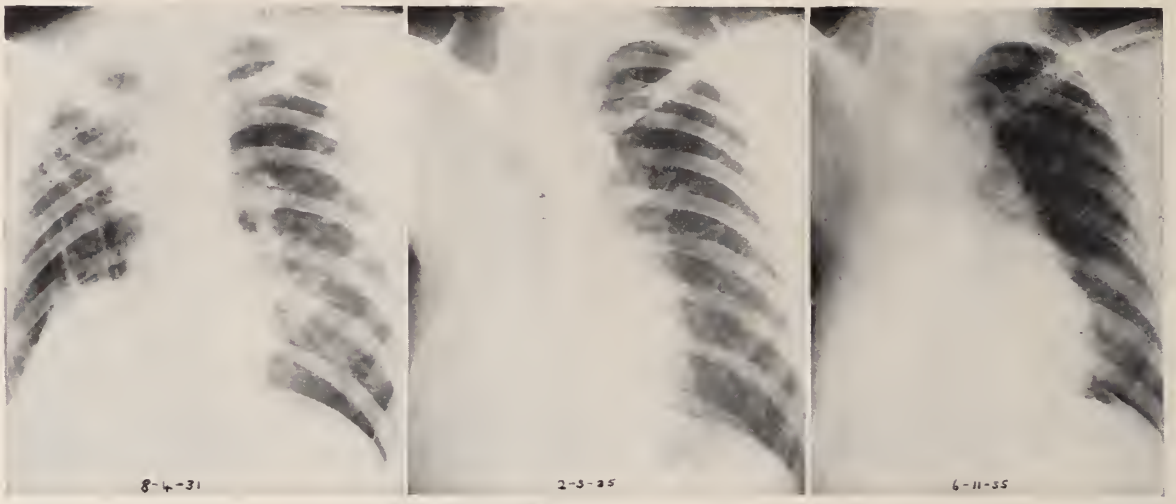


Fig. 4.—Three thoracoplastic procedures failed to close a large cavity, remains of which can be seen just below the clavicle protected by transverse processes, by regenerated ribs and by stumps of ribs anteriorly. Resection of these elements led to closure of the cavity. Elimination of cough and sputum, and apparent cure.

this intelligent patient was convinced that collapse of the cavity was necessary for cure.

In another instance the revision of a thoracoplasty, previously performed elsewhere in three stages, necessitated not only the resection of transverse processes, but also resection of the anterior stumps of the first, second, and third ribs to obliterate the cavity (Fig. 4).

SPECIAL INDICATIONS

Not infrequently, a localized apical abscess, though constituting the most intractable focus, is only part of a more generalized process involving ipsilateral and contralateral lobes. Under such circumstances it is highly important to conserve as much as possible of the uninvolved lung and of the already greatly reduced vital capacity. A complete unilateral thoracoplasty may be definitely contraindicated because of bilateral disease and because too much healthy pulmonary tissue would be sacrificed thereby. Since surgical collapse of the apical abscess or dead space is absolutely imperative if cure is to be effected, some form of partial thoracoplasty is indicated. This may involve, in certain instances, only a single operation (Fig. 5), consisting of complete resection of the upper three ribs from vertebral to sternal attachments. In other instances it may be necessary to perform, in addition, a partial resection of the fourth, fifth, and possibly sixth ribs, including also resection of the

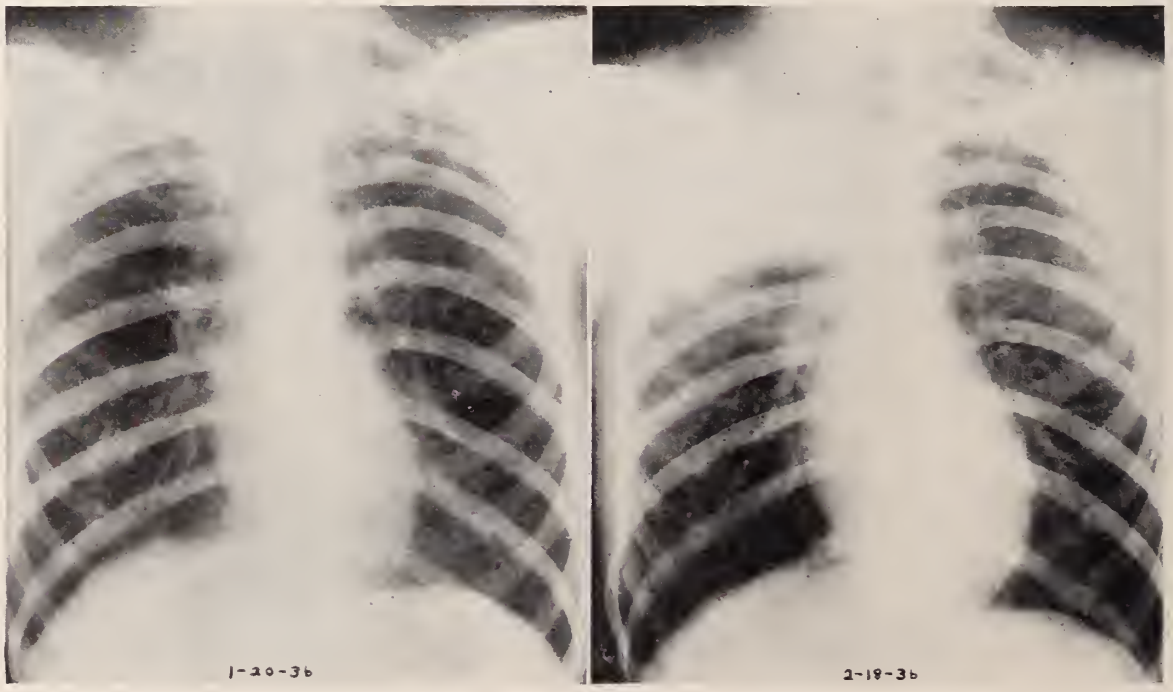


Fig. 5.—Bilateral apical abscesses with displacement of trachea and mediastinum to right. Resection of upper three ribs resulted in closure of the right abscess and marked diminution of cavity on left by restoration of mediastinum to normal position with relaxation of apical tissues on left.



Fig. 6.—Large apical abscess, unsuccessfully treated by pneumothorax and incompletely closed by resection of upper three ribs, is completely closed by the partial resection of additional four ribs, and pushing in of the scapula. The patient is well.

transverse processes of the third, fourth, and fifth vertebrae (Fig. 6).

Occasionally the greatest obstacle to the maximum benefit from such a partial thoracoplasty is the scapula. If only five ribs are resected, the scapula effectively prevents the complete falling in of the posterior thoracic wall. If only six ribs are removed, the lower angle of the scapula rides on the seventh rib, causing localized pain and elevation of the shoulder. The resection of seven ribs may be too formidable for patients with the type of general involvement under discussion, and the additional sacrifice of good lung and of vital capacity is unwarranted when the sole object is obliteration of an apical cavity.

OPERATION: PARTIAL RESECTION OF THE SCAPULA

Such reasoning led to the resection of the lower third of the scapula as an alternative procedure to resection of the sixth and seventh ribs (Fig. 7). This resection is easily performed, with a minimum of bleeding, by an incision around the angle of the scapula, elevation of the periosteum and of the attached muscles by a broad sharp elevator, and excision of the bone by rongeurs. Enough bone is removed to permit the scapula to fall easily into the space provided by resection of the upper five ribs.

This operation of partial resection of the scapula for the collapse of an apical cavity may be done in one or two stages (Fig. 8). Following the complete resection of the upper three ribs and portions of the fourth and fifth, the menace of paradoxical respiration is always great, depending upon the thickness and rigidity of the parietal pleura. Accordingly, if removal of the upper three ribs causes active paradoxical movement of the mobilized chest wall, the operation is terminated, and at the second stage, ten to fourteen days later, the fourth and fifth ribs, and occasionally the sixth, are partially resected together with the lower third or half of the scapula. If the paradoxical movements are only moderate, due to fibrous rigidity of the visceral and parietal pleurae, the operation may be completed in one stage (Fig. 9). In fact, the falling in of the small, partially resected scapula may effectually prevent paradoxical respiration and may, therefore, permit completion of the operation in

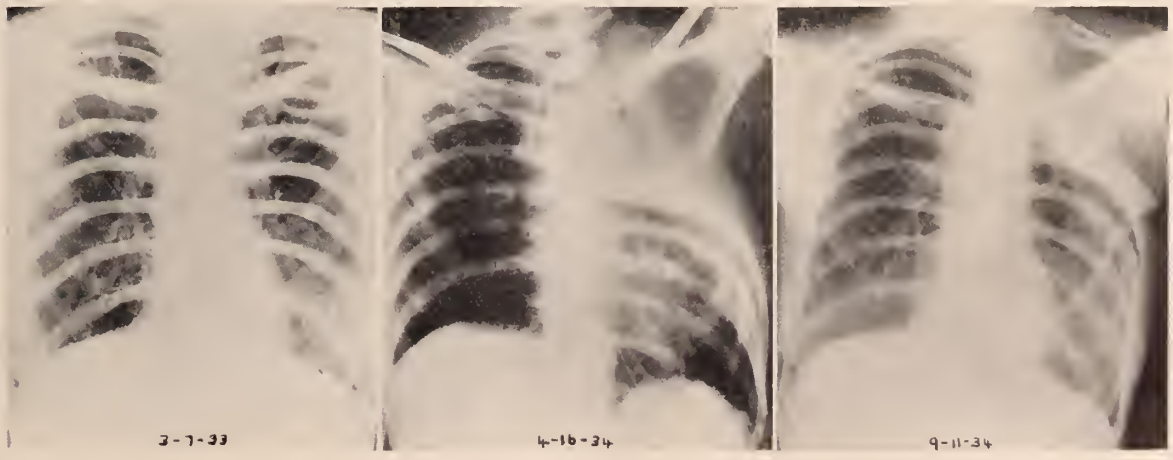


Fig. 7.—Bilateral tuberculosis with large left apical abscess completely closed by resection of five ribs and partial resection of scapula. Patient much improved, but still has tubercle bacilli in sputum.



Fig. 8.—Large apical abscess, incompletely closed by pneumothorax, closed by complete resection of upper three ribs, partial resection of fourth, fifth, and sixth ribs, and resection of lower third of scapula. Patient apparently cured.

one stage. Further experience with the operation will be necessary to determine this point.

SUMMARY

Pulmonary tuberculosis is frequently characterized by a large apical abscess, which forms the most intractable focus of the disease. Such an abscess must be closed, either by reëxpansion of good lung or by compression. There is no alternative—healing will not occur unless closure of the cavity is effected.

For such an abscess, localized selective collapse is preferable to the usual complete paravertebral thoracoplasty. A limited thoracoplasty may be necessary because of (1) bilateral involvement of lungs; (2) necessity for conserving good lung at the base; and (3) the abscess may be displaced rather than compressed by the old-fashioned paravertebral procedure.

Aids in effecting complete collapse of apical abscesses are:

1. Complete resection of the upper three ribs from transverse process in back to costal cartilage in front.

2. Resection of transverse processes over the site of the abscess. When thoracoplasty threatens to displace peripherally situated abscesses into the paravertebral gutter, resection of the transverse processes over the area likely to be occupied by the abscess in its new position is indicated.

3. Resection of the lower third of the scapula, which permits more complete compression of the involved lung by the falling in of a scapula greatly reduced in size, and obviates the need for sacrificing good lung at the base.

Revision of inadequate thoracoplasties for incompletely collapsed cavities should not be a repetition of previously ineffectual procedures, but should include resection of the transverse processes over the site of the abscess and, when necessary, resection of the anterior stumps of ribs through an anterior incision.

In the presence of bilateral apical abscesses, a unilateral upper thoracoplasty may be effective in relaxing the opposite apex, thus providing better conditions for healing of both abscesses by one operative procedure.

Thoracoplasty as a therapeutic measure should not be condemned or abandoned until the offending cavity has been effectually and completely collapsed.

Stanford University Hospital.

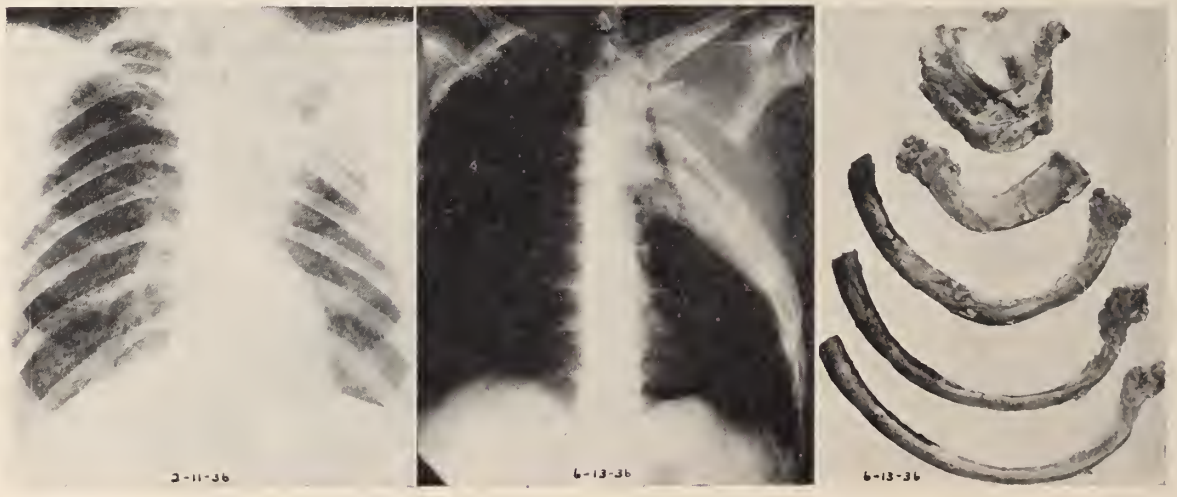


Fig. 9.—Bilateral tuberculosis with large apical abscess closed by resection of four ribs and partial resection of scapula. Patient much improved, but still under sanatorium care.

DISCUSSION

Robert A. Peers, M.D. (Colfax).—Someone has said, "It was a brave man who first ate an oyster." It was a braver man who first performed extrapleural thoracoplasty for the closure of cavities resistant to pneumothorax or other measures. That thoracoplasty has survived, and has become a recognized and important method of treatment where pneumothorax and other measures fail, is due, perhaps, as much to good fortune as to skillful surgery. Fortunately, in spite of what we know now to have been insufficient removal of the proper constituents of the lung cage and what we realize was, at the time, too extensive surgery in the removal of parts of too many ribs, enough patients recovered from the shock of operation and a sufficient percentage recovered their health to encourage surgeons to improve their technique and their surgical judgment. Had the mortality been higher and the percentage of recoveries smaller, what is now a very valuable adjunct to antituberculosis treatment might have been lost forever or at least postponed for a long period. Herein, as noted, fortune played a hand.

Experience showed that what often was needed was a multistage operation instead of a shock-producing one-stage attack. Experience also showed that the removal completely of a few of the upper ribs, together with the transverse processes, together with partial removal of two or more lower ribs, would result in success where failure was common when parts of many more ribs were removed. Doctors Holman and Pierson have explained why this is so. They have still further improved on the method by removal of part of the scapula where conditions indicate the advisability of this measure. As the authors have pointed out, the plan of attack as outlined by them enables them to save much useful healthy pulmonary tissue.

The author of this discussion can, from personal experience, heartily endorse all that has been said by Doctors Holman and Pierson. With carefully selected cases, operated on as outlined with individual surgical resources adapted to individual cases, we now have in thoracoplasty a means of saving many lives which were hopelessly doomed before the advent of this additional procedure of thoracic surgery.

❦

Hans Schiffbauer, M.D. (520 West Seventh Street, Los Angeles).—I quite agree with the contents of Doctor Holman's paper. More ill-advised and inadequate thoracoplasty operations are being done than ever before, and many of these patients will have residual cavities which produce positive sputum.

Many surgeons have felt that when a complete posterior thoracoplasty has been supplemented by some form of anterolateral resection of the remaining sections of ribs with their costal cartilage, and after months of careful sanatorium treatment, a cavity still persists with a positive sputum, nothing more can be done.

Doctor Holman has beautifully shown that these cases can be successfully reoperated, removing the bony plate with the transverse process over the existing cavity in the diseased lung, producing complete obliteration of the existing cavity.

After the removal of the transverse processes there is a greater tendency to scoliosis, especially in children. So, instead of removing the transverse processes, I have disarticulated the neck of the ribs from the transverse process, also disarticulated the head from the vertebrae with its periosteum, and using caution not to leave more than a minimum of denuded bone in the operated field. After three to five such stumps are removed, with sharp and blunt dissection, the parietal pleura can be separated from the lateral vertebral column, which allows the diseased lung to shrink up, leaving the transverse processes undisturbed.

Doctor Holman brought out the necessity of removal of the lower portion of the scapula. This is very necessary in partial selective thoracoplasty where larger sections of the sixth and seventh rib are not removed. At times it may be advisable to remove six to eight centimeters of the entire vertebral border of the scapula in order not to have the scapula interfere with adequate collapse over the operated area.

In all of the more recent thoracoplasty after section of the rib at transverse process, I remove the neck and head by disarticulation with its periosteum, beginning with the third rib. I am certain, in so doing, that I have obtained greater collapse of the diseased lung without damaging the transverse process, which is an advantage to the patient.

❦

F. M. Pottenger, M.D. (Pottenger Sanatorium, Monrovia).—In recent years surgery of the chest has developed quite rapidly. It has offered hope to a certain group of patients who could not possibly have gotten well without it.

While the healing of tuberculosis is brought about through the patient's own physiologic reactions, the mechanical conditions must be favorable or such healing cannot occur. Loss of tissue causes shrinking of the lung volume, and unless the remaining portion of pulmonary tissue is able to enlarge and fill in the thoracic cage, cavity walls remain apart, tension is put upon the pulmonary structures, and healing is interfered with.

The proper form of chest surgery suited to the individual case acts by improving the mechanical condition, thus allowing physiologic healing to take place.

One of the problems which has baffled clinicians since attempts were first made to treat tuberculosis has been the apical cavity. While now and then such a cavity would epithelize and become dry, as a rule it continues suppurating as long as the patient lives and frequently is the focus from which the disease spreads to other parts of the lung. Operation of such cavities in the past have not been very successful in bringing about closure. Doctors Holman and Pierson discuss in a very satisfactory manner certain reasons for this failure.

Inasmuch as surgery alone offers hope for the patient suffering from a large apical cavity, clinicians have been free to recommend them for surgery, only to be disappointed in the result obtained.

The authors discuss two measures which will make this operation more satisfactory: first, the resection of the transverse processes of the second, third, fourth, fifth, and possibly sixth vertebrae, depending upon the size of the cavity; and second, the resection of the lower third of the scapula, so as to allow the chest wall to fall in and complete the approximation of the cavity walls.

While it is very fortunate that patients with tuberculosis should, in such large numbers, be permitted to go on to the formation of large apical cavities, it is gratifying that surgeons are able to devise a technique which offers them hope of relief.

ABDOMINAL HERNIAS*

THE USE OF AUTOGENOUS STRIPS OF FASCIA LATA IN THE REPAIR OF THE MORE DIFFICULT ABDOMINAL HERNIAS

By Donald C. Collins, M.D.
Los Angeles

Discussion *by Hall G. Holder, M.D., San Diego; C. Latimer Callander, M.D., San Francisco; E. Eric Larson, M.D., Los Angeles.*

FOR clinical purposes, abdominal hernias may be grouped into two classes: First, those of a simple character in which a very large number of cures result from operative measures; and, second, that smaller group where ordinary standard surgical procedures usually lead to failure and recurrence. Members of this second group are: direct inguinal, sliding, postoperative, diaphragmatic, recurrent, and the large indirect inguinal hernias—so frequently observed in the elderly, debilitated patient.

* Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

In this second group surgeons have recognized these facts. They have used various kinds of nonabsorbable sutures as various types of wire, linen, silk, and silkworm gut. Of the absorbable materials employed, catgut and ox or kangaroo tendon are still the most popular sutures. The enthusiastic advocation of multiple techniques and suture materials to be used in a successful hernioplasty is sufficient proof of the inadequacy of present methods of repair. We are seeing an increasingly greater number of unsuccessful attempts at cure in this group by the injection of various sclerosing solutions in the vain hope of closing the hernial defect by the formation of inflammatory scar tissue.

AUTOPLASTIC SUTURES

Lewis Linn McArthur,[7] in 1904, published his final report on the use of autoplastic sutures in the repair of hernia and other diastases. This was a report of the use, in his clinic, since the year 1896, of autoplastic strips of the external oblique aponeurosis instead of foreign suture material in inguinal hernioplasties.[9] Few surgeons paid much attention to McArthur's method, or to the underlying principles of the use of autoplastic fibrous tissue in the place of absorbable foreign sutures. Subsequent reports in the surgical literature upon the use of McArthur's technique have shown excellent results, with a negligible percentage of recurrences. Postmortems done on individuals who had had such a repair done previously, and then had later died from causes unrelated to their hernioplasty, demonstrate that the transplanted sutures of aponeurosis had lived and were firmly united to the tissues through which they passed. Active proliferation of connective tissue could be seen originating from such sutures. Dr. C. W. Mayo[8] in recent years has successfully used this method in the cure of inguinal hernias. In hundreds of his patients that have now been followed for two or more years, there has been less than one-half of one per cent of recurrence.

LIVING AUTOGENOUS STRIPS OF FASCIA LATA

Between the years of 1921 to 1930, Gallie and LeMesurier[2,3,4,5] firmly established the value of living autogenous strips of fascia lata derived from the individual patient. They have popularized the use of this material not only in inguinal hernias, but also in the largest and most difficult varieties of this second group. These authors conclusively demonstrated that either pedunculated or free strips of fascia lata will continue to live indefinitely so long as they are able to receive an adequate supply of lymph and tissue plasma. The tensile strength of fascia lata has been estimated to be 750 pounds in a straight pull before rupture will occur. This, of course, far exceeds the tensile strength of any absorbable foreign suture that we may employ. They also found that this amazing tensile strength was unchanged and was not lost in the free transplanted strips of the patient's own fascia lata. However, this method had a major objection to its universal use by surgeons, because it necessitated the making of a long incision along the lateral surface of the thigh so that the tendon of the tensor fascia lata muscle could be exposed, from which the fascia lata strips could be obtained. This difficulty was removed by the perfection of a fascia lata stripper by Dr. J. C. Masson,[10] during the year 1933. In 1935, Masson[11,12] did much to popularize this method of treating these more difficult abdominal hernias by the presentation of two timely articles, which were widely read by the surgical profession.

REPORT ON HERNIAS AMONG STEEL WORKERS

The recent report of Foster[1] on 101 unselected cases of hernias occurring among steel-mill workers, in which autogenous sutures of fascia lata was used, is of great interest. His patients returned to full duty within six months following their hernioplasty. Many of these individuals were elderly, possessing atrophic tissues together with huge hernias. The end-results proved to be far superior to former methods employed. In only two of the seven recurrences was faulty operative technique to blame. Most important of all, these seven were again repaired with additional strips of autogenous fascia lata, and they have had no further recurrences.

MASSON FASCIA LATA STRIPPER

The Masson fascia lata stripper consists of two steel tubes that telescope one over the other. The outer tube is shorter and has a knife edge on its distal end. The inner tube forms the handle of the instrument and has an eyelet at its distal end. The outside tube is threaded at its upper end so that it can be screwed onto the inner tube just below the handle. With the instrument thus assembled, the cutting-knife edge is well above the eyelet of the inner tube and can do no damage to neighboring tissues. The skin of the lateral aspect of the thigh, over the proximal portion of the tendon of the tensor fascia lata muscle is incised for a distance of 5 centimeters, and the tendinous portion is exposed. A strip is then dissected out of the tendon, about 2 centimeters in width, and then the strip is lengthened for a distance of 5 centimeters. Then the fascia strip is threaded through the eyelet of the stripper and securely grasped by several hemostats. The stripper is forced down the thigh until it lodges in the neighborhood of the external condyle of the femur. The outer tube is then unscrewed and, with several twisting motions, the knife-edge cuts off a strip of fascia lata the length of the subcutaneous extent of the stripper. Additional strips can easily be obtained in a similar manner. These strips are then split longitudinally in the direction of their fibers, into narrower strips of about half a centimeter in width. The individual strips thus obtained are threaded onto thick, heavy short needles that are securely tied on by ligatures of black silk. The other end of the strip is also securely tied by a similar ligature. After taking the first two stitches, the needle is passed back through the strip close to its ligated end, thus forming a slip-knot which will firmly secure it. Fascia lata can only be fastened in this manner because of its inability to remain tied in a square knot. After this

first strip has been used up, another is similarly prepared and fastened to the first strip by a similar use of a slip-knot. The needle is removed from the first strip, making certain that a secure ligature of black silk has been tied there to prevent the fraying out of the end of the strip. Thus, each strip is fastened onto the preceding one for the purposes of security. As additional measures of security, the sutures are allowed to pass through one another as a basket-weave suture wherever possible. The last suture is ended by suturing the free end down with black silk to neighboring strong tissues and doubly tying it there. Chromic catgut has been found unsatisfactory as ligature material and will easily slip off of the fascia strips, thus endangering the entire hernioplasty.

OTHER PROCEDURES

One can usually obtain enough fascia lata strips from one thigh to repair even the largest of hernias. These hernial defects are closed without tension. If the edges cannot be reapproximated with ease, then the defect is closed by weaving in a basket-weave closure of strips. The resultant defect in the tensor fascia lata muscle causes no discomfort, but I warn my patients that such a muscle hernia will follow their hernioplasty, but that it is of no consequence. Most surgeons make the mistake of attempting to obtain fascia lata from the more anterior and medial portions of the thigh, with the usually dismal failure as their reward. It is only in the fibers of the tendon of the tensor fascia lata muscle that the fascia lata can be easily stripped off for any appreciable distance, and done safely. The thigh incision is closed tightly in layers with the use of one retention-suture of silkworm gut for supportive measures, as the thigh receives considerable active motion in bed postoperatively. All of my hernioplasties remain in bed for at least three weeks or longer, depending on the character of their postoperative convalescence. All hernioplasty incisions are drained dependently for the first seventy-two hours following surgery, in an effort to prevent the formation of incisional hematomas or the collections of serum which do so much toward lengthening the postoperative convalescence of your patient. Every effort is made to prevent the formation of dead spaces in the incision. I pay very little attention to whether the patient is obese, because, with the use of living sutures, the problem of excessive intra-abdominal pressure tearing down the hernioplasty can be disregarded, since you are suturing structures with a suture that has a tensile strength of 750 pounds to the square inch of pull. As a consequence, bites with the fascia needle are deeper and include more tissue than would be done if foreign sutures were used. No particular effort is made to clean off the adipose tissue from muscles or fascial structures before suturing them together, inasmuch we are dealing with a living suture which, as time goes on, will become increasingly stronger and will actually proliferate fibrous tissues from its fibers. The obtaining of the fascia lata strips and the resuture of the thigh incision should not take more than five to seven minutes to complete, when the Masson fascia lata stripper is employed. All of my patients wear an adequate Scultetus abdominal binder while in bed and an efficient abdominal supportive belt for one year following their dismissal from the hospital. Whenever possible, I insist on the use of a spinal anesthesia to obviate abdominal straining and to insure maximum relaxation of the abdominal wall.

INDIRECT INGUINAL HERNIAS

I have been using a modified McArthur technique in the surgical treatment of indirect inguinal hernias, with one recurrence, so far, in a group of eighty-three patients so treated, and followed for at least two years since the time of their operation. After the reduction of the hernial contents and a high ligation of the hernial sac with its transposition up behind the conjoined tendon, two strips of external oblique aponeurosis one centimeter in width are cut. One strip is left attached to the spine of the pubis while the other is left attached to the cephalic end of the external oblique muscle. A modified Bassini hernioplasty is then done, using these two strips of aponeurosis as running mattress sutures to close the inguinal canal, by suturing the conjoined tendon down to Poupart's ligament and particularly strengthening the internal ring. The external oblique is also sutured beneath the cord for additional strength. If the conjoined tendon is found to be weak and of little value in the lower portion of the inguinal canal, strips of autogenous fascia lata are taken and the resultant defect is filled by a basket-weave type of suture that very easily closes the opening without tension.

VENTRAL OR INCISIONAL POSTOPERATIVE HERNIAS

In instances of ventral or incisional postoperative hernias, particular attention is paid to overlapping the edges of the hernial opening. Often valuable tissue can be salvaged from the hernial walls for this purpose. This scar tissue is sutured to the muscle tissue of the opposite side, and vice versa. Thus, a double layer of tissue is first used in the preliminary closure of the peritoneal cavity, which is secured by ordinary absorbable sutures. To prevent the recurrence of the hernia following some sudden increase of intra-abdominal pressure, such as may follow coughing, sneezing, or straining at stool, additional support is provided by the use of autogenous fascia lata sutures either as mattress sutures or in the form of a basket-weave to strengthen the former hernial site. These sutures take bites into the imbricated repair and deep bites out into neighboring normal tissues. Never should an attempt be made to draw muscles together under excessive pressure, as this will only lead to eventual necrosis of the sutured muscle and the repair will break down due to faulty operative technique, and not due to any fault of the fascia sutures. Interrupted mattress retention sutures of silkworm gut are used to obliterate dead spaces in the incision, and thus discourage hematoma formation or the collections of serum which may lead to secondary wound infections. If such a complication does

occur, the fascia repair will usually hold, but the incision will not heal until all of the silk knots have been removed. Thus, particular care is taken to have the preoperative preparation as thorough as possible, which includes a sterile preparation of the skin of the operative site the day preceding surgery. Interestingly, most of these patients show a fever of only 99.0 or 99.5 degrees Fahrenheit for the first two days postoperatively. Postoperative morbidity and complications are far less when autoplastic fascia sutures are used.

UMBILICAL HERNIAS

In umbilical hernias the hernial opening is enlarged to expose the edges of the recti muscles. The Mayo overlapping closure is performed, suturing the cleaned peritoneal portion of the upper flap to the anterior rectus sheaths of the lower flap, using forty-day chromic catgut. The imbrications are further strengthened by the use of autogenous fascia lata sutures. Interrupted retention sutures of silkworm gut are used to obliterate dead spaces in the incision. The superficial portions of the incision are closed by layers. The dependent portion of the incision is drained for the first seventy-two hours following operation.

FEMORAL HERNIAS

In femoral hernias in which there is a large femoral canal, I use strips of fascia lata to firmly close the hernial defect. Following the reduction of the hernia and the high ligation of the sac, the femoral canal is blocked by mattress fascia lata sutures taken through the upper portion of the pectineus muscle and thence passed up the canal and through the external oblique just cephalad to Poupart's ligament. This simple procedure works very well and is quickly done. In five cases so treated there have been no recurrences to date.

DIAPHRAGMATIC HERNIAS

In large diaphragmatic hernias the defect is first closed by overlapping the margins of the hernial opening for a distance of 3 centimeters by the use of interrupted mattress sutures of linen. This suture line is then further strengthened by running mattress sutures of autogenous fascia lata strips. This makes the strongest possible closure obtainable. If there has been considerable loss of diaphragmatic muscle or its attachment to the thoracic wall has been torn, fascia lata strips are invaluable and will give a strong permanent closure.[6]

REPORT ON FORTY-FOUR CASES

I wish to briefly report my experiences with forty-four patients in whom the Masson-Gallie technique was closely followed, using autoplastic fascia lata strips. There were no deaths either in the hospital nor during their convalescence. Twenty-six were males. In only one individual is there some doubt as to whether there might be a newly developed weakness in the inguinal region lateral to the site of the repair of a huge postoperative ventral hernia following the removal and drainage of a gangrenous perforated appendix. The hernia of this patient was repaired less than one year following the appendectomy, and promptly developed an acute wound infection in a supposedly clean case. The thigh incisions healed *per primum*. It is highly probable that latent infection existed in the tissues of the anterior abdominal wall from the first operation. It was necessary, in this instance, to secondarily open the incision superficially and remove all the silk knots. This was followed by prompt healing of the incision. Four individuals had gangrenous incarcerated ventral incisional hernias in which portions of the small intestine, varying from 16 to 74 centimeters, were resected. Gastro-intestinal continuity was restored by the performance of aseptic end-to-end anastomoses, without a fatality. In eight instances the fascia repair was done in the presence of gross contamination, and all of these hernioplasties have held and are well healed today. There was only one wound infection in a supposedly clean case in this series, and the details of that case are given above. Table 1 summarizes the data of this group of patients and records the salient facts.

IN CONCLUSION

1. The use of autogenous fascia lata sutures has given a higher percentage of cures in the more difficult types of abdominal hernias than was formerly possible.

2. The Masson fascia stripper affords an easy and rapid means of obtaining an adequate supply of fascia lata without resorting to large incisions in the thigh.

3. Spinal anesthesia is the anesthesia of choice in these cases.

4. Obesity is no longer a contraindication to a prompt hernioplasty.

5. Forty-four cases of the more difficult types of abdominal hernias are reported in which the Masson-Gallie technique was closely followed. There were no deaths and only one questionable slight recurrence.

6. Eighty-three additional cases are included of indirect inguinal hernia in which the McArthur technique was followed. There was one recurrence. There were no deaths.

TABLE 1.—*Summary on Report of Forty-four Patients: Masson-Gallie Technique*

Number of patients reported upon	44
Sex:	
Males	26
Females	18
Deaths	None
Recurrences (questionable)	1
Clean cases	36
a. Wound infections	1
Dirty cases	8
a. Secondary operations to remove silk knots	3
Obese individuals	31
Age:	
a. Average age	47.8 years
b. Youngest individual	38 years
c. Oldest individual	71 years
Average number of fascia lata strips used per patient	5.2
Average time per operation (minutes)	98
Anesthetics used:	
a. Spinal	35
1. Procain	28
2. Combined	7
b. Ether	3
c. Ethylene	3
d. Cyclopropane	3

Types of Hernia:

1. Inguinal	15
a. Direct	9
b. Huge indirect	6
2. Incisional	15
a. Previous mid-right rectus incision	8
1. Upper abdomen	3
2. Lower abdomen	5
b. Previous mid-line incision	7
1. Upper abdomen	2
2. Lower abdomen	5
3. Umbilical	6
4. Femoral	5
a. Women	4
5. Diaphragmatic	2
a. Side of diaphragm: Left side	2
6. Epigastric	1

1930 Wilshire Boulevard.

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DISCUSSION

Hall G. Holder, M.D. (1107 Medico-Dental Building, San Diego).—Doctor Collins' presentation is timely, as little improvement in end-results has occurred in herniorrhaphy since Bassini introduced his method of radical repair in 1899. In the repair of inguinal hernias three general principles are universally agreed upon following the advent of the radical operation, namely, (1) complete dissection of the inguinal canal, with particular attention to the removal of all areolar tissue, so that firm union may be had between either muscle and fascia, or between fascia and fascia; (2) high ligation of the sac, preferably with transplantation high under the internal oblique muscle; and (3) plastic reconstruction of the inguinal canal.

The different types of reconstruction can be classified simply into three main groups: (1) Bassini's original description of the transplantation of the cord; (2) Non-transplantation of the cord, as advocated by Ferguson; and (3) Extra-apponeurotic transplantation of the cord, as typified by Halstead, Andrews, and others. The tremendous advantage of the use of fascia lata over ordinary suture materials in the repair of hernias, particularly difficult types of hernias as related by Doctor Collins, is further emphasized by reviewing the recent literature on the subject. Using only the best sources, I find reported 3,275 cases of indirect inguinal hernia repaired without fascia, giving an average recurrence rate of 5.5 per cent as against 188 reported cases in this same condition in which fascia was used with a recurrence rate of only 2.6 per cent. Still more striking, the average recurrence rate using foreign suture material in 804 direct hernias reported in the literature was 16 per cent, as against a recurrence of only 3.5 in 252 cases repaired with fascia. No definite information could be obtained regarding the recurrence rate of recurrent hernia, but it is only fair to believe that this would be much higher than the 16 per cent for the direct hernia. I find only forty-five cases of recurrent hernia repaired with fascia with a recurrence rate of 6.6 per cent reported, which undoubtedly is far below that of the ordinary suture material.

Until the year 1935 my records show that I performed forty-five Galli fascial repairs with a recurrence rate of 2.2 per cent, and twenty-seven McArthur herniorrhaphies with a recurrence rate of 3.7 per cent. At the same time I reviewed 103 cases of indirect inguinal hernia which had been repaired with the ordinary suture materials in which I had a recurrence rate of 6.7 per cent. Therefore, in my own hands, using identical technique with the only variable suture material, I obtained one-third less recurrences in the more difficult cases using fascia over other suture materials.

Points in technique which I think are important, and which I repeat for emphasis, as Doctor Collins has mentioned most of them, are: extra-aponeurotic transplantation of the cord, high ligation of the sac with transplantation, closure of the transversalis fascia, careful cleaning away of all of areolar tissue from fascial and muscle structures, so as to allow a two or more layer repair of the inguinal canal beneath the cord with the fascial sutures.

As Doctor Collins has indicated, I believe that the fascial stripper simplifies the obtaining of the fascial sutures which can usually be done by an assistant with no loss of operating time. In the placement of the sutures, I prefer to employ a fascial suture clamp which I devised, instead of the Galli needle, as it permits of more rapid suturing with much less traumatization of tissue. This latter is a very important point, I believe, in obtaining the best results in this type of repair, as most failures come from excessive traumatization from the large Galli needle with sewn-in fascial suture.



C. Latimer Callander, M.D. (450 Sutter Street, San Francisco).—Doctor Collins has given us, in a clear-cut and painstaking manner, the case for the use of autoplastic fascia lata in the repair of all varieties of rupture. So many able surgeons now employ fascia lata transplants in hernial repair as a matter of routine that I am convinced of the general utility of this suture material. Antagonists of the method cannot overlook the manifest fact that a fascia lata suture holds opposed surfaces over a broader area than does any other material, and, in addition, unites with the opposed tissues. No other material can be woven into a living overlay over a gross tissue defect. Masson's stripper has made collection of the sutures a simple step in the operation.

It was well to call attention to the pioneer work of McArthur in this field. His method of using attached strips of the external oblique aponeurosis from the edges of the inguinal hernia incision can be utilized in all indirect inguinal hernias and in most direct ones. This method, however, only allows sufficient suture material to unite the incision in the external oblique aponeurosis, and to approximate the conjoined muscle and tendon to the shelving edge of the inguinal ligament. Gallie and Le Mesurier have carried their investigative work and clinical applications in autoplastic suture material far further than did McArthur, and soundly established their method of tissue approximation.

With the contention, however, that aponeurosis will not unite firmly to muscle when held in place by either catgut or silk ligature, I am heartily out of accord. Anyone who has had occasion to repair many recurrent ruptures cannot fail to recall instance after instance in which sharp-knife dissection was required to separate the lower margin of the internal oblique and transversus abdominis muscles from the inguinal ligament. The failure of the hernia operation often is not a faulty new wall, formed in front of or behind the cord, but is a result of not ligating the hernial sac sufficiently high.

E. Eric Larson, M.D. (1930 Wilshire Boulevard, Los Angeles).—Until recent years much confusion as to the best procedure for repair of large ventral, recurrent direct and inguinal hernias, has existed. Tabulated statistics of data have shown that recurrences existed in surprising proportions. Past military activity and the advent of rigid physical examinations of all employees, especially in the heavy industries, have placed a burden on the successful surgical attack of hernias.

For these reasons, and for the added fact that there must be progress in surgical technique, the essayist has today brought to our attention the use of autogenous fascia for more successful repair.

Doctor Masson's method of obtaining strips of fascia lata is a distinct contribution. Experimental studies have revealed that transplanted fascia becomes incorporated as living tissue in about one year. Therefore, the strength and permanence of this tissue, which neither stretches nor contracts, adds to the permanence of closure and successful treatment of these defects.

This is especially true in large ventral hernias where much tissue may be lacking. A basket-weave type of fascia stripping, much like darning a hole in a sock, has been a most salutary and welcomed procedure. Where there is enough tissue, strips of adjacent fascia are woven into the suture lines. The result of this added suture has given excellent and permanent support to the sutured edges. Harrington's use of fascia in the repair of large diaphragmatic hernias has added an amazing permanence to this type of repair, since very few recurrences are reported when fascia is used.

I have used fascia strips for fourteen years, and in the obese patient or those over forty years of age with inguinal hernia I incorporate strips of the aponeurosis of the external oblique into the sutures, as first described by L. L. McArthur in 1901.

The intelligent use of fascia is becoming world-wide, and will no doubt afford us better statistics in a short time.

TONSILLECTOMY: A PLANNED, COMPLETE OPERATION*

By William Remfry Hunt, M.D.
Santa Barbara

Discussion *by Frank S. Baxter, M. D., Oakland; W. H. Johnston, M. D., Santa Barbara.*

THE purpose of this paper is to discuss, and demonstrate with slides of removed tonsils, a planned complete removal of the palatine tonsil and its lymphoid appendages, with particular emphasis on the latter. It may seem strange to take time to discuss the most commonly operated tissue, the tonsil; however, the surgical technique of this important structure cannot be overemphasized. As we all know, the two main methods are: (1) with the various types of tonsillotomes or guillotine instruments, (2) with the variable dissection and snare method.

ANATOMY

The palatine tonsils lie in the oropharynx. The arterial supply to the tonsils from branches of the external carotid are the ascending palatine and anterior tonsillar of the external maxillary (facial), ascending pharyngeal, the dorsum linguae branches of the lingual, and the descending palatine branch of the internal maxillary. The venous drainage through the tonsillar and pharyngeal plexes enters the facial veins. The nerve supply comes through the lingual branch of the fifth, and from the ninth, tenth, and sympathetics. Over the upper pole, the capsule is separated from deeper structures by loose areolar tissue (the most common site of peritonsillar abscess). Below this the capsule is intimately blended with the muscles, namely, the palatopharyngeus or posterior pillar, the palatoglossus or anterior pillar, and laterally partly by the superior constrictors of the pharynx. The plica semilunaris is a fold of mucous membrane joining that of the pillars medial to the upper pole of the tonsil. The plica triangularis is a fold of mucous membrane which extends medially and downward from the margin of the anterior pillar, surrounding the lower pole like a sling. This appendage contains masses of lymphoid tissue. It extends to the pharyngeal border of the tongue. Here the lymphoid masses may be termed lateral lingual tonsil. Below the lower pole of the tonsil proper is a subtonsillar lymphoid chain of varying amounts of lymphoid tissue, lying against the muscles and covered by mucous membrane. This subtonsillar lymphoid tissue may extend downward as far as the pharyngo-epiglottic fold.

It is my opinion that all this lymphoid tissue should be removed in every tonsillectomy. Some laryngologists have advocated removing the tonsil and not disturbing these lymphoid appendages routinely; but doing so at a second operation if subsequent examinations indicate that they are a septic focus of infection. However, few, if any, patients would return to the original surgeon for a second operation. As there is no objection to their removal, and they are frequently definitely septic, and they are a common site of recurrent acute inflammation, it seems well worth while to give the patient the maximum benefit of an initial complete tonsillectomy.

While it does not come directly within the subject of this paper, I may mention the lymphoid tissue, especially the lateral lymphoid bands on the pharyngeal wall. This tissue is present in a large percentage of people in every age group, especially preadolescents. It is more abundant in the so-called lymphoid types. Why some people have more lymphoid tissue on the pharynx than others is not known. The writer has observed it more often in the allergics and hypothyroids. That its presence is due to posterior sinus infection, alone, is contrary to my experience. That, if present, it becomes readily inflamed with any inflammation of the upper respiratory tract is an almost daily clinical observation. If someone has not already done so, may I suggest the term "lymphoid pharyngitis," as preferable to "granular pharyngitis" for this condition. As a rule, I remove these pharyngeal lymphoid masses, if of consequential size, when doing a tonsillectomy. If present, they are the most common site of sore throats, when an otherwise successful tonsillectomy has been accomplished.

TECHNIQUE

The writer has attempted to rationalize his surgical technique to strict anatomical detail.

In tonsil surgery, good lighting, making for good vision, is vital. Direct reflection from a head mirror over the eye is best. The Klaar lamp or similar

* Read before the Eye, Ear, Nose, and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

reflection may be satisfactory. The ordinary head lamp, with indirect light reflected from the forehead, is inadequate, and accounts for many remnants being overlooked that can be seen with good lighting. When a tenaculum such as the Tydings grasps the tonsil, the plica and anterior pillar become tense. Initial sharp incision is made through the mucous membrane exactly at the border of the anterior pillar, near its upper limit. This incision, exposing the capsule, is carried down to the tongue, thus removing the plica from the border of the anterior pillar. A Seiler's knife, similar to the Dean, except that the former has a slight curve, is used to begin the operation after the initial sharp incision, and for much of the subsequent dissection. Returning toward the upper pole, muscle fibers are pushed off or incised from the capsule under direct vision, as a curved incision through the mucous membrane extends upward and medially. With the knife over part of the upper pole, the tonsil may be pushed down, releasing that portion from the loose areolar tissue at the extreme apex of the fossa. Now, curved scissors are used to make an accurate incision close to the tonsil in the upper medial portion through the plica semilunaris. This is more certain than tearing the upper medial portion of the tonsil from the posterior pillar. Carelessness at this point results in a raised palate on that side, due to the injury to muscle fibers of the palatopharyngeus which blend with those at the base of the uvula, and the action of the levator veli palatini muscle on the injured palate. With the upper pole partially free, the tenaculum is placed in the upper pole, including its capsule, and the dissection continued downward under direct vision. With the Hurd dissector or Seiler's knife, depending upon the amount of adhesions, the posterior pillar is completely freed from the capsule of the tonsil, likewise the anterior pillar. It may not be necessary to free the entire lateral wall to the level of the tongue, but I always do so. The tonsil now lies loose in the fossa attached only at the lowest anterior and lateral portion of the lower pole, and by its subtonsillar lymphoid appendage.

The tenaculum is now carefully placed so that the lower pole, particularly, is included in the grasp. The snare is placed over the tonsil and drawn up loosely to a smaller loop. The tongue depressor is removed, allowing the tongue, especially the lateral portion, to be free to rise. The loop of the snare is almost parallel to the lateral wall of the pharynx. As the lower pole is pulled up, the snare wire is pushed down, and the snaring is completed. When the tonsil is examined, it will be found present in capsule, with all or most of the lymphoid appendages: plica, lateral linguals, etc., attached. A thorough inspection is now made of the subtonsillar area, and any additional lymphoid masses are removed with the Allis and snare. The most difficult area to be sure of is the extreme posterior lateral border of the tongue. This may be examined with the Allis forceps, gently feeling for and grasping any lymphoid masses, not readily apparent when using the pillar retractor and tongue depressor alone. Careful inspection of the fossa frequently reveals a few small extracapsular lymphoid masses at the apex, or behind the anterior pillar. These may be pulled off with an Allis, if small, or snared off, if large.

If there is actual or threatened bleeding, particularly from the upper pole, the vessel is grasped superficially with an Allis forcep, and a superficial suture, using "0" or "00" catgut, is placed. When the fossa is clean and "dry," it is lightly swabbed with 2 per cent mercurochrome, or with 3 per cent tincture of iodin, which must be handled more carefully.

The other tonsil is removed in a similar manner.

Under local anesthesia, the procedure is almost bloodless. Under general anesthesia any free bleeding, particularly from the upper pole, is stopped with a superficial suture during the dissection. The upper pole of the tonsil being pressed down with the tongue depressor, and the edge of the fossa raised with a retractor, any bleeding area here is readily seen. By controlling this type of bleeding, the remaining dissection and snaring offers only a slight ooze. In this way blood loss is maintained at a minimum; tracheal aspiration and other hazards are reduced. Postoperative bleeding, either primary or secondary, rarely occurs. Under local anesthesia the tongue depressor may be dispensed with most of the time, as the view over the angular tenaculum is adequate. This adds greatly to the comfort of the patient.

COMMENT

Some statistics on so-called tonsillectomized children given in the general literature, have little, if any, value. The assumption that any patient who has undergone a tonsil operation by any physician, so often untrained and unskilled, is always tonsillectomized, is contrary to clinical observation.

Infected tonsil remnants, like infected dental remnants, may be a serious menace to good health, and should receive meticulous surgical attention.

Tonsils operated with the various tonsillotomes should have the plica, lateral lingual, and subtonsillar areas cleaned up at the time. Plical remnants on the anterior pillar should be excised with knife or scissors. Other remnants may be removed with the Allis and snare, or a similar procedure, as none of these instruments, alone, include all the lymphoid appendages of the tonsil.

Younger physicians should be taught a less casual and more respectful attitude toward tonsillectomies.

Results of successful surgery on previously incompletely operated tonsils, particularly with rheumatic conditions, such as acute iritis, arthritis, etc., are thoroughly convincing.

IN CONCLUSION

Accurate smooth dissection under direct vision leaves clean fossae, minimizes trauma, promotes easy convalescence, gives a good cosmetic result, and obtains for the patient maximum benefit from the planned complete tonsillectomy.

1421 Chapala Street.

DISCUSSION

Frank S. Baxter, M.D. (1624 Franklin Street, Oakland).—We all know that tonsillectomies are done by surgeons of varying ability and dexterity. It follows, as a

natural course, that those tonsils which are removed with a full understanding of the immediate anatomy are entirely removed. Careful inspection of the fossae, and particularly the plica triangularis and the adjacent lymphoid tissue, is vitally important. The instruments used in a tonsillectomy are a matter of individual preference, but the fundamental thing of importance is a painstaking, nontraumatic, complete removal of the tonsils. A focus of infection is thereby eliminated, which is the real reason for removing the tonsils.

W. H. Johnston, M.D. (1515 State Street, Santa Barbara).—We all acquire a technique for this operation after we have been in practice a few years, and I believe that we should continue to use the method which, in our hands, has given us the best results. Most of us try to do the complete operation described by Doctor Hunt, but I fear that we are not all getting the ideal end-results in 100 per cent of our cases. I have had the experience, many times, of completing what I thought was a perfect job, only to find a few months later a mass of lymphoid tissue at the lower part of the tonsillar fossae. I have also had the experience of doing a somewhat hasty operation and later finding that the end-result was perfect. We are overlooking something in the patient's make-up, and must remember that there are cases which we might call of the lymphatic type in which it seems impossible to do any type of operation that will insure against regrowth of lymphoid tissue at the lower pole. In this class we must look for some etiological factor, the discussion of which might go on indefinitely and does not belong under the heading of this paper. Some years ago French described an operation which he called "extended tonsillectomy"; it was quite similar to the one described by Doctor Hunt in reference to the lymphoid extension to the base of the tongue.

I agree with the essayist that many quoted statistics mean very little, because a considerable number of the operated cases retain remnants of infected lymphoid tissue in the tonsillar fossae. Most of us agree, I believe, that a piece of infected lymphoid tissue hemmed in with scars is much more harmful than was the original tonsil in many instances before an incomplete operation was performed.

I believe that we should all have a less casual attitude toward the tonsil operation, which now seems to come into the field of so many branches of the medical profession.

DRUG ERUPTIONS DUE TO THE BARBITURATES*

By Frederick G. Novy, Jr., M.D.
Oakland

Discussion *by Harry E. Alderson, M.D., San Francisco; Stanley O. Chambers, M.D., Los Angeles; Philip K. Allen, M.D., San Diego.*

THE purpose of this paper is to discuss briefly the different types of cutaneous manifestations that may follow the use of the barbiturates.

Today the barbituric acid derivatives, of which there are a large number, have a widespread use in medicine for their sedative and hypnotic effects. Since these drugs were first introduced, eruptions of different types have been reported. Toxic skin reactions appear frequently following their administration, and should be constantly watched for. Menninger[1] states that about 2 per cent of the patients taking phenobarbital (luminal) develop some form of cutaneous intolerance. All of the barbiturates have been responsible for reactions, and there is no one form which is less likely to produce trouble. Phenobarbital and barbital (veronal), however, are the ones most frequently mentioned in the literature. This, I believe, is because of their more widespread use rather than that they are more toxic.

Why certain individuals react to these drugs is not fully understood. Undoubtedly the patient's general condition plays an important rôle. We see patients in good health who tolerate a drug, and later, when their general health has been impaired, a reaction to the same drug takes place. In these instances interference with the elimination of the drug could be a factor. A disturbance of the cardiorenal system would lead to retention of fluids and storage of the drug in the tissues. Other patients, probably the majority, have an idiosyncrasy to the drugs. This hypersensitivity can be explained in some patients who, having taken the drug some time in the past, have apparently become sensitized. Then later, upon administration of the same drug, a reaction occurs. This would account for the clinical fact that urticaria, a type of response that one would expect with hypersensitivity, is extremely common. Wise and Sulzberger[2] feel that nearly all drug eruptions fall into this category of sensitization reactions.

Dosage does not appear to play a great part, as exceedingly small amounts will produce eruptions in sensitive individuals. Babington[3] reported a patient who developel a toxic eruption the second day after having taken only two one-quarter grain doses of phenobarbital. Other cases have been reported in which large doses, over a considerable length of time, had been given before any cutaneous reaction was noticed.

CUTANEOUS MANIFESTATIONS

The types of cutaneous manifestations seen are: (1) urticarial; (2) erythematous; (3) bullous; (4) eczematous; and (5) fixed.

Urticarial Type.—This is probably the most frequent. The eruption appears immediately, or a few hours after administration of the offending drug. The reaction may be mild, with a few scattered wheals, or may take on the more serious form of angioneurotic edema, with extreme swelling of the affected part. This reaction must be differentiated from urticaria due to some other cause. Stopping of the medication should be followed by a clearing of the condition in a short time, if that is the causative factor.

Erythematous Type.—This form usually appears on the chest and face as brilliant, light-red macules, which may become diffuse if medication is not stopped. If the reaction is severe, the eruption may become universal. This may be followed by a generalized exfoliative dermatitis. Lancaster[4] reported such a case following the taking of phenobarbital. There is nearly always a great deal of pruritus. Edema, particularly about the eyes, is usually part of the picture, and there is an associated conjunctivitis. The mucous membrane of the mouth and the throat may become involved. The mucosa of the rectum and genitalia may also be affected. Frequently there is a slight rise in tem-

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perature. Temperatures of 103 and 104 degrees have been reported. In these cases gastro-intestinal symptoms are usually present. A moderate leukocytosis is present with an increase in eosinophils. These may be as high as 22 per cent. A differential diagnosis must sometimes be made between this type of eruption and scarlet fever or measles. At times this is extremely difficult. A careful history is of importance. The absence of pain and marked injection of the throat would be against scarlet fever. Ordinarily there is not a marked adenopathy with the drug eruption. The tendency of barbiturate eruptions to clear promptly upon withdrawal of the drug is of help. The blanching test for scarlet fever is an aid in distinguishing the two conditions. The absence of Koplik's spots, and the prodromal coryza, would differentiate the drug dermatitis from that of measles.

Bullous Type.—This type is not seen frequently. It is usually associated with the severe erythematous type. The vesicles may vary from miliary size, which are usually transient, to that of large bullae and blebs, simulating pemphigus. The mucous membranes are frequently involved. Weber [5] has reported a case in which there was jaundice along with the bullous eruption. Hemorrhagic bullae also have been described. Following the formation of blebs, extensive ulceration and necrosis have occurred. Mailer [6] reports an interesting case of this kind, in which the reaction was due to nembutal (sodium ethyl—one methyl-butyl—barbiturate). In this case large wheals first appeared on the thighs, followed by vesicles which coalesced into bullae. Necrosis rapidly followed, involving one-half of the anterior portion of the thigh. Similar cases have been seen by Coste and Bolgert,[7] following the use of barbital. The necrotic areas occurred at the sites of pressure appearing as acute decubiti.

Eczematous Type.—Bering [8] recently described a group of five cases in which the clinical picture was that of a papulovesicular eczema. Three of the patients had a primary dermatitis, following the long use of barbiturates. In the other two the eruption was secondary to a chronic pruritic eruption.

Fixed Type.—A fixed eruption is one characterized by recurrences in exactly the same locations. The affected areas usually become pigmented, and at the time of exacerbation are pruritic. This type of reaction, due to several of the barbiturates, has been observed, but is not widely recognized. Wise and Parkhurst,[9] Goldenberg and Rosen,[10] and Fowlkes [11] make mention of this condition caused by these drugs. Loveman [12] published the description of a case following the use of allonal which contains alurate (allylisopropyl-barbituric acid). Langenbach,[13] reporting four cases of dermatitis following the use of sodium amytal (sodium iso-amylethyl barbiturate), states that there was some pigmentation, and that in one case, upon repeating the drug, the eruption did occur in the same areas. From his description, however, one cannot be sure that he was dealing with a fixed eruption. I have seen one case in which this type of reaction was found to be due to amytal.

REPORT OF CASE

N. F., female, age thirty, was referred to me for consultation by Dr. C. Cocks. Her chief complaint was recurrent itching patches on the right wrist and left buttock. Examination revealed two circular, sharply circumscribed, hyperpigmented areas of a purple-red hue. The one situated on the dorsum of the right wrist was of dollar-size. The other, on the left buttock, was of palm-size. The rest of the skin was clear. A clinical diagnosis of fixed eruption was made.

The eruption had been present for the past four or five months. It came on suddenly and there was a marked pruritus of the affected areas which lasted several days. The symptoms then cleared. Exacerbations have since occurred at irregular intervals. After each attack the patient noticed that the pigmentation gradually became deeper. Her general health had been good, except for some nervousness and insomnia. For this she had been taking different medicines, including allonal.

The patient was asked to take several tablets of allonal, but no exacerbation took place. Further questioning revealed the fact that, in addition to the allonal she had, on occasion, been taking sleeping capsules that were prescribed for her mother. These were found to be amytal (iso-amyl-ethyl barbituric acid). A few hours after taking one of these capsules, there was a severe exacerbation, with pruritus and deepening of the color of the lesions.

From this observation it was apparent that the exciting factor of this patient's eruption was due to the amytal.

FURTHER OBSERVATIONS

Effect of Other Drugs Producing Fixed Eruptions.—The patient was then instructed to take aspirin and phenolphthalein. Both drugs are known to produce fixed eruptions. There was no reaction. This again confirms similar experiments by Abramowitz [14] and the author [15] on phenolphthalein, and by Loveman [12] on allonal, in which it was shown that an individual with a fixed eruption is not susceptible to all the drugs that cause this type of lesion.

Effect of Taking Other Barbiturates.—She had previously taken allonal with negative results. One-half grain of phenobarbital (phenylethyl-barbituric acid) was given, and there was a definite flare-up of the eruption. Later, when the condition had subsubsided, she was given barbital (diethyl-barbituric acid). Again there was a severe exacerbation, appearing in about twelve hours. As amytal, barbital, and phenobarbital, all contain ethyl-barbituric acid, it was thought that the eruption might be due to this radical. She had not reacted to allonal (allyl-iso-propyl barbituric acid), which does not contain ethylbarbituric acid. Loveman [12] found in his case which reacted to allonal that there was no reaction to the other barbiturates.

Effect of Split Products.—Several split products of barbituric acid were kindly furnished by the Eli Lilly and Company. They were iso-amyl-ethyl malonamid; iso-amyl-ethyl malonic acid; iso-amyl-ethyl acetyl urea; iso-amyl-ethyl acetic acid; iso-amyl-ethyl acetamid. One-half grain doses were administered without reaction. This shows that the eruption was not due to some split product of barbituric acid, which could have been formed in the body.

Patch Tests.—Patch tests were performed in the usual manner with amytal and the split products named above. All were negative. This has been

the usual finding with fixed eruptions. This observation would support the idea that hypersensitiveness in these cases is not in the epidermis and superficial part of the cutis, but is in the deeper layers of the skin.

TREATMENT

These eruptions usually involute rapidly on withdrawal of the offending drug, and no treatment is necessary other than a mild antipruritic, as calamin zinc lotion. Occasionally, in the more severe forms, active treatment is necessary. Johnson [16] and Sanderson [17] have reported good results with the intravenous injection of large amounts of 5 or 10 per cent glucose. A 4 per cent solution of sodium bicarbonate has also been used intravenously when large doses of the barbiturates have been taken.

SUMMARY

Skin eruptions due to the barbiturates are common. Any barbituric acid derivative is capable of producing the different cutaneous reactions which have been described. These reactions are urticarial, erythematous, bullous, eczematous, and fixed.

A case is reported of a fixed eruption due to amytal. Further observations on this patient showed that only the barbiturates with the ethyl-barbituric acid radical would reproduce the eruption.

411 Thirtieth Street.

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DISCUSSION

HARRY E. ALDERSON, M.D. (490 Post Street, San Francisco).—I have seen numerous examples of eruptions due to all the drugs mentioned, excepting amytal. As I prescribe amytal a great deal in small doses, for the relief of pruritus, I may some day see a case of dermatitis medicamentosa due to this drug.

STANLEY O. CHAMBERS, M.D. (826 Roosevelt Building, Los Angeles).—This particular subject, dealing with drugs so commonly employed in general medicine, seems most apropos. It is appreciated by the author that cutaneous reactions of the common order are familiar to most of us. The intriguing portion of the presentation deals with a fixed eruption. This picture is infrequently identified, and yet relatively common. The discusser has witnessed such lesions about the scrotum and anal region, considered as recurrent scrotal eczema and pruritus ani. These lesions appeared in direct proportion to the ingestion of the drug, and disappeared with its withdrawal. Recurrence was always at the same site. Greater consideration of such possibilities should increase therapeutic effectiveness.

Doctor Novy is to be complimented for his interpretation of such an unfamiliar dermatitis.

PHILIP K. ALLEN, M.D. (314 Medico-Dental Building, San Diego).—The widespread use of many different barbiturate derivatives and the inevitable intolerance exhibited by some individuals to their use, make the subject an important one.

I think that the fixed eruption is the most interesting type of the drug idiosyncrasies. Its exact place in the field of hypersensitive reactions is still a debatable point. The reaction is not only independent of any circulating antibodies (as shown by the absence of the Prausnitz-Kustner phenomenon), but is confined strictly to certain groups of the fixed tissue cells. Similar tissue outside the reacting areas fails to exhibit the phenomenon, so that cutaneous tests are of little significance except in the areas previously involved.

An interesting feature of Doctor Novy's case is the degree of specificity shown to a certain type of barbiturate derivative. It is frequently of great value to know that a hypersensitivity to one type of drug does not imply that related substances will produce the same reaction.

ACUTE GONORRHEAL ARTHRITIS COMPLICATING PREGNANCY*

By JOHN R. UPTON, M.D.
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DISCUSSION *by Karl L. Schaupp, M. D., San Francisco; Frances Baker, M. D., San Francisco; William Benbow Thompson, M. D., Los Angeles.*

THE comparative rarity* of acute gonorrheal arthritis complicating pregnancy, and the peculiar problems which arise in its treatment during the pregnant state, warrant a consideration of the subject, a review of the literature, and the reporting of a case. The "Index Medicus" for the last ten years contains no articles on this subject.

LITERATURE

Lindermann,[1] in 1892, appears to have been the first man to connect the gonococcus with the resultant complicating arthritis. Jundell,[2] in 1894,

* By permission of the San Francisco Public Health Department, Dr. J. C. Geiger, director.

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and Aehman,[3] in 1897, recovered the gonococci from infected tendon sheaths. Edgar,[4] in his 1903 volume of Obstetrics, makes no reference to the gonococcus during pregnancy, but does state: "The etiology (puerperal septic arthritis) is evident from the pathology. It has been seen, however, as the result of gonorrheal infection. There is always considerable danger of destruction of the joint and of permanent anchylosis and loss of function." Webster,[5] in 1907, only says: "It (gonococcus) may be carried to distant parts, *e. g.,* joints, endocardium, and pleura, and set up pathological processes. The marked liability of pregnant and puerperal women to acute gonorrheal infection must be noted; and also the tendency to development in these states of an acute exacerbation of what was previously a slight infective inflammatory process. Thus a latent condition may develop into an acute outbreak in pregnancy, or in the puerperum, without any fresh infection from without." Lea,[6] and Taussig,[7] and Harrar,[8] likewise made further advances in the study of the gonorrheal organism as a causal factor in arthritis. DeLee,[9] in 1915, briefly calls attention to the increased vascularity and succulence of the vaginal tissues, and the appearance of the vaginal mucosa when infected. Royston,[10] in 1923, reported four cases of pregnancy complicated by gonorrheal arthritis; these were the first histories I could find reported in the literature, and I shall have occasion to refer to them more fully later. Williams,[11] in 1926, in his volume on Obstetrics, stresses the rôle played by the gonococcus during the puerperium, but makes no mention of any complicating disorder during pregnancy.

DIAGNOSIS

Diagnosis[12,13] should present few difficulties. The question of pregnancy is usually self-evident. A characteristic history for gonorrhea from the husband, wife, or both, may or may not be elicited. The gonorrheal infection responsible for the acute arthritis appears to be most frequently acquired after conception takes place.[10,11] The isolation [14,15] of the Neisserian organism from the vaginal tract leaves no possibility of doubt—if the smears have been prepared by the use of Gram's staining technique. On this well-known clinical picture of gonorrhea, and usually within four weeks' time, is superimposed a rather suddenly severe fever, chills, some prostration, sweats, shifting pain in the skeletal articulations, swelling of the joint capsules and adjacent tendon sheaths, with final permanent localization of this acute pain in some one or more skeletal junction. In a few patients where repeated vaginal and cervical smears are negative for the Neisserian cocci, or, in patients who are too close to term to warrant the vaginal manipulation incident to the cervical visualization, the complement-fixation test is of real assistance in establishing a diagnosis; the test should be routinely performed. Intradermal tests with the gonococcal filtrates are not specific and, therefore, they are misleading.

Many physicians, in order to establish a diagnosis, aspirate some fluid from the affected joints or tendon sheaths, but this procedure, I believe, is attendant with considerable risk to the patient. The gonococcus organisms are difficult to culture and isolate from such aspirated fluid, even though the joint spaces are washed carefully, and the resultant liquid centrifuged. The possibility of a secondary infection makes a seemingly simple procedure fraught with danger. The above questionable diagnostic procedure is nullified, however, when an acute purulent tenosynovitis occurs; for in such a case the treatment is surgical incision and drainage.

SOME GENERAL CONSIDERATIONS

A few general considerations must be disposed of first, for certain pertinent side issues continually creep into the discussion and refuse to be ignored. The pregnancy must be considered as a complicating factor. The period of gestation is of importance; Royston's[10] four cases all developed their acute arthritis in the latter half of pregnancy, and my reported patient was in the twenty-ninth week of pregnancy; therefore, from the few reported cases the impression is obtained that the arthritic manifestations occur in the last trimester. Earlier writers[4,5] believed that many spontaneous abortions occurring in the first trimester were caused by a gonorrheal infection, with the disease being contracted at or shortly after impregnation occurred. This infection, they believed, caused an endometritis and deciduitis which, if severe enough, would precipitate an abortion. The presence of a fetus complicates matters greatly, but suffice to say that, if it is possible for the patient to carry through to term, so much the better for the ultimate results. Any mechanical interference in the earlier months of pregnancy through the vagina, in order to induce an abortion, will unseal the route to the abdominal cavity. This permits the causal gonococcus an opportunity to initiate, and form the tubo-ovarian and pelvic manifestations so familiar to all gynecologists.[12,13] Astrinsky and Grinner[16] report 30 per cent of complications when induced abortion occurred in their series of cases of gonorrhea. Gonorrheal arthritis is sown by an infected blood stream. Contiguous invasion from the infected Bartholin, Skene, and cervical glands is usually prevented after conception by natural cervical barriers, but if these are destroyed by surgical or criminal interference the utero-tubo-abdominal passageway is again patent. Another cautioning factor against indiscriminate therapeutic abortions is the strong possibility of a secondary invader obtaining a foothold in the excellent pabulum created by the unavoidable trauma incident to the surgical interference. The most-feared organism is the hemolytic streptococcus.[17] The resultant infection would also be augmented by the general lowered body resistance of the patient due to the infective arthritis.

The available evidence indicates that the acute infectious process is due to the gonorrhea having been contracted after conception occurred. An old gonorrheal infection frequently prevents fertilization by occluding the fallopian tubes, while if the disease is localized in the lower genital tract, attenuation of the cocci may result. Williams[11] states that many puerperal fevers are flare-ups of a qui-

escent antepartum infection. The diminished virulence might be the result of conservative treatment if recognized, or again it might be the reaction due to an increased resistance on the part of the maternal body defenses. When postconceptional in character, the invading organism is fresh and virulent, while the maternal tissues, being succulent and hypervascular due to the pregnancy,[9] offer an excellent medium for multiplication and for possible invasion; trauma to the vaginal mucosa or the cervix abets the infection. Several investigators[18] have shown that pregnancy increases the resistance of the maternal body to disease; were it not for this fact[19] many more women would present the acute gonorrheal arthritic symptomatology. As it is, the disease is rare, whereas vaginal gonorrheal infections during pregnancy are quite common;[16,20,21,22] Taussig[7] reported 5 to 10 per cent, Royston[10] 3 per cent, and Rorke[22] 16 per cent of their clinical patients.

TYPES

Acute gonorrheal arthritis is either monoarticular or polyarticular. Multiple joint involvement appears most frequently; this fact is rather fortunate, for when one joint alone is diseased the course is frequently stormy, as an inflammation of the tendons and tendon sheaths may take place, and a high percentage of cases progress into a purulent tenosynovitis. If a purulent tenosynovitis supervenes, the original condition must be subordinated until adequate surgical measures[23,24] have cleared away the septic infection between the tendons and delicate sheaths. Frequent, minute examination of all involved joints and adjacent tendons is mandatory to circumvent such a chain of distressing events.

The Neisserian organism appears to have a predilection for the upper extremities in women, and for the lower members in males. The wrists, elbows, metacarpal and phalangeal joints, shoulders, sternoclavicular articulations and knees are attacked most frequently in women. Complete ankylosis of one or more joints is the most fearsome aftermath, and the condition to be guarded against. Royston[10] tells us that all four of his cases suffered some permanent damage; Kanavel[25] warns against the possible dire results after a gonococcal arthritis. A vexing question is the problem of splinting the involved members; there is a wide diversity of opinion as to whether splints are necessary.

TREATMENT

Nature immobilizes diseased articulations and tendons rather effectively, but we can aid and encourage nature, and at the same time provide more comfort for the patient. When the elbow or wrist is involved—and these two constitute the commonest sites—logical treatment, based on anatomical considerations, is to apply a posterior arm supportive plaster splint with the elbow held in the mid-flexion attitude, the forearm in midsupination, and the wrist assuming a slight dorsiflexion. This type of support is easily removed so that passive and active massage may be instituted at the proper time.[25] Involvement of distal extremities, likewise, demands adequate support of the involved members. The physician should be rather cautious, however, for splinted patients may rely overly much on this artificial rest, with the resultant freedom from discomfort. Atrophy of muscle groups, tenosynofibrosis, and sometimes bony ankylosis takes place, a truly dire catastrophe. Splint if necessary, but always encourage the patient to move her involved members within the angle of painless motion when the splint is removed. This slight activity will stimulate peripheral circulation, prevent marked muscle wasting, prevent and break up tendon adhesions, and will greatly lessen the danger of joint fixation. When these patients first present themselves for treatment, roentgen-ray studies of the affected joints should be taken, for then we have valuable comparison films for use at a later date. Films frequently show involvement of the bone in the form of an osteitis; therefore, interval pictures will shed necessary information on the progression or retrogression of the disease. This being so, the roentgen films constitute valuable adjuvants in the treatment of the patient, for by their interpretation of the bony lesions the calcium-phosphorus therapy can be intelligently administered. We should not forget that such records are also medico-legal safeguards for the doctor.

Sagging, pendulous breasts require support. A snugly fitted uplift brassiere will give great relief. My patient complained bitterly about her heavy breasts resting on the extremely tender bicep muscles, but when the pressure was relieved by an uplift brassiere she instantly remarked on the improvement. A minor point, but one which the patient heartily welcomed.

The heart, like a good campaigner, frequently takes care of itself, but it behooves the physician to protect it throughout the tedious illness.[26,27] If the heart has been damaged by former infections, greater watchfulness is necessary, for the high fever and toxic condition multiply the work of the organ many times. Bodansky[28] says that an increase of one degree centigrade in the body temperature causes a rise in metabolism of about 13 per cent. Lewis[29] says that "rest is essential until active mischief is no longer suspected; an object of rest is to avoid strains of joints or increased work of the heart that may help to light up active trouble; return to exercise must be very gradual." The friendly counsel of a cardiologist is warmly appreciated in dealing with such a damaged heart during pregnancy[30] when other contributing factors are present.

RECENT THERAPEUTIC MEASURES

Modern therapeutic measures directed against gonorrheal arthritis in the nonpregnant state are now uniformly effective.[31-34] When, however, we are forced to deal with a pregnant woman suffering with an acute gonorrheal arthritis, we must of necessity modify one of the newest and most effective weapons in the therapeutic armamentarium, *i. e.*, hyperpyrexia or hyperthermia. Under

the heading of hyperpyrexia, I shall only include:

1. Hypertherm cabinets. The air-conditioned hypertherm cabinet is perhaps the best of the present-day apparatus, but as yet I believe it has not been manufactured commercially. Hench, et al.,[31] report of this machine that, "of patients with gonorrheal arthritis, well over two-thirds are promptly cured, and practically none go without considerable relief." Owens[32] says: "Given patients who can and will take the treatment, better than 80 per cent of gonococcic infections, regardless of complications, may be absolutely cured in the space of two weeks."

2. Diathermy.[35-40]

(*a*) Contact metal electrodes.

(*b*) High frequency alternating electric field.

(1) Cable and coil; double cuff.

(2) Electric-field electrodes.

(3) Glass or composition, air-separated electrodes.

(*c*) High frequency electromagnetic field.

3. Hydrothermia.[41-43] Total or partial immersion can be used. Various clinics advocate varying degrees of heat, and different methods of application.

4. Nonspecific foreign protein therapy. In this group, typhoid vaccine given I. V. has had the stellar rôle. Cecil, Friess, et al.,[44] report disappointing results with malaria. Sterile milk injections[45] are not without danger to the patient.

Systemic hyperthermia should not be used for the pregnant patient suffering from acute gonorrheal arthritis, since the products of conception always suffer, and death of the fetus may occur when the body temperature is elevated, and sustained for any period of time. This fact is demonstrated by the many intra-uterine deaths caused by the various organisms which have, as one of their manifestations, the disturbance and elevation of the heat-regulatory mechanism. Pneumonia is an example. It is possible to modify some one of the above hyperthermic methods, but the physician must realize fully that the sensitive heat-regulatory centers in the gravid patient will tolerate less interference, and that the line of demarcation between the normal and pathological is more obscure. Local hyperthermic measures will give some certain relief, but, as Harrison[46] trenchantly puts it, "The primary focus of infection should be treated first, then measures are instituted to sterilize the blood stream, and the joints are treated last of all." Here diathermy produces beneficial results.

It might be advisable here to inject a word of warning, as it has been shown that the improper usage of short-wave diathermy machines is not without real danger.[35,36,47] Cartilage is devoid of circulation and sensation, possessing neither protecting nerves nor cooling blood vessels. If injured, articular cartilage has no power of regeneration, and little power of repair.[48] When short-wave diathermy machines are used, particularly referring to the double-cuff application method, the above warning is real. Deeper tissues sustain higher temperature rises, so that if, for instance, the knee joint is under treatment, the physician must be aware of the irreparable damage he may inflict to the articular cartilage of the knee. Some knowledge of electricity and physics is essential. Cardiac collapse, embolic phenomenon, hemorrhagic encephalitis, vascular collapse, and deterioration and hemorrhage of the suprarenal glands have all been encountered by those who have used this newer method of fever therapy.

Extremely gratifying results are frequently encountered when local roentgen-ray therapy is carried out by a competent roentgenologist.[49,50] Adequate screening[51] of the pelvic contents to avoid fetal and maternal damage is, of course, mandatory. Indiscriminate use of these roentgen rays might only show their harmful effect in later generations. Our reported patient responded more quickly to local x-ray therapy than to any other treatment; we were most favorably impressed with the results obtained.

In evaluating the results obtained by any of the hyperthermic methods we should realize that it is the production of heat, and heat alone, that aids; so far as now known, there is no specific bacterial action other than that produced by the increased rise of temperature.[37]

Chemotherapy has its staunch partisans and equally fervent opponents. I have not used this debatable form of treatment.

In regard to drugs, as with the hyperthermic measures, we are again confronted with the inevitable question, will the fetus suffer damage? Naturally, the mother's life must not be jeopardized nor her pain left unrelieved for want of administering necessary sedatives or analgesics. The salicylates, opium derivatives, quinin, and the cinchophens, judiciously used, will give considerable relief. Weak links in the maternal chain must be constantly sought for. Irritative drugs are prone to hurt an already damaged kidney; therefore, a daily urinalysis is indicated to pick up the first signs of a nephritic condition.*

Multiple small blood transfusions and intravenous 10 per cent dextrose are excellent supportive measures; especially is this true during the high-fever stage.

OTHER THERAPEUTIC FACTORS

A brief listing of certain other cogent factors which will intrude themselves for solution are: the eradication, if possible, of the primary source of infection and the cleansing of other nonspecific foci of infection; the choosing of a diet rich in vitamins and supplemented with some form of easily assimilated iron—trays which tempt the appetite and do not repulse; the approaching problem of vaginal delivery versus cesarean section; if the birth is per vaginum, to safeguard the child's eyes by adequate treatment, and if the baby is a female, to recall that the vagina of the new-born girl may be infected during the descent via the maternal birth canal; the baby should be bottle-fed from the start, to prevent any possibility of infection from the mother to the child, etc. Lamb[52] says that there is

* I am now studying the effect of prontosil and prontolyn in relation to the above condition, and hope that I may be able to report the results later.

a short period during and after birth when the vaginae of female babies are difficult to infect with the gonococci, due to the influence exerted by the theelin contained in the maternal blood. If this is true, it would partially explain the relative rarity of gonorrheal vaginitis in the new-born baby girls, even following breech deliveries.

PROGNOSIS

A favorable prognosis depends, necessarily, on various pertinent factors, but we may postulate: that if the bony destruction is minimal, and the angle of movement only partially restricted; if the heart has not suffered additional damage; if the kidneys function satisfactorily; if the primary source of infection has been adequately treated, and, finally, if the patient comes through the ordeal of labor successfully, then we may reasonably hold out the promise of a complete cure.

All patients should be followed for varying intervals after their discharge from the hospital, for ambulatory treatment is always necessary. A prolonged convalescence, abetted by a general building-up regimen, spells for greater end-result success.

REPORT OF CASE

A case of acute gonorrheal arthritis complicating pregnancy is hereby summarized:

Mrs. G. B., a primiparous white American housewife of twenty-two, entered the San Francisco County Hospital on August 29, 1935. Her complaints were: Severe upper extremity joint pain and stiffness for six days' duration. She had never attended a prenatal clinic.

Past History.—Resided in San Francisco for the past year. Previous to that she resided in Illinois, where she was born. She drank a moderate amount of alcohol up to the time she became pregnant. She had no menstrual irregularity until she became pregnant. L. M. P., January 11, 1935. E. D. C., October 18, 1935.

Present Illness.—One and a half months prior to entry she first noticed a vaginal discharge which gradually became worse, and quite profuse during the past two weeks. Her husband had had gonorrhea. Was treated; no urethral discharge for some weeks. One week previous to hospital entry she noticed stiffness of back, neck, shoulders, legs, ankles, toes, and fingers; any movement was attendant with great pain. Two days later the stiffness and pain became localized in the elbows, which became slightly swollen and exquisitely tender.

Physical Examination.—Temperature was 100 degrees Fahrenheit, pulse 130, respirations 22. A young woman, who cringed and whimpered if any attempt was made to examine her arms.

The skin was moist and pale, and the excessive perspiration necessitated frequent changes of nightgowns. Generalized flea-bites. Heart sounds not unusual, rate 130; blood pressure, 125/85. Uterine fundus was 25 centimeters above the S. P. Position of fetus R. O. T. sounds regular, but rapid—at 160 per minute. The child's head settled in the pelvis. Pelvic mensuration was within normal limits. The arms were held in half-flexion; shoulders, elbows, and wrists were exquisitely painful; some swelling at joints. Any attempt to examine the patient caused her to cry in an hysterical manner. There were no signs of a purulent tenosynovitis.

Laboratory Work.—Urethral and cervical smears were positive for neisserian intracellularis.

Complement-fixation test was positive. Wassermann, negative.

Sedimentation time was eight minutes. Blood: Hemoglobin, 80 per cent; red blood cells, 4,830,000; white blood cells, 12,400; polymorphonuclears, 78 per cent; lymphocytes, 22 per cent; type two, Moss.

X-ray report showed osteitis of both margins of the symphysis pubis, both wrists and elbows.

Urine: Catheterized specimen showed many bacteria, but otherwise negative.

Diagnosis.— Pregnancy, intra-uterine, seven months. Acute polyarticular arthritis, neisserian. Gonorrhea, subacute—skenitis, specific; cervicitis, specific. Tenosynovitis, bilateral wrists and elbows.

Treatment.—Absolute bed rest. High vitamin diet supplemented with cod-liver oil and iron. Massive hot compresses applied four times a day, from fingers to shoulders, with slight decrease of pain. Later on, local hot bakes by use of electric cradle; poor result. The arms were supported with slings at first; later, posterior splints were applied, with great relief to the patient. Gentle massage to arms and shoulders three times a day, using oil of wintergreen. Fluids forced to 4,000 to 5,000 cubic centimeters per day. One ounce of 6 per cent mercurochrome was injected into the vagina once every three days. Acetyl salicylic acid, sodium salicylate, and phenobarbital were the only drugs used.

Five intramuscular injections of gonococcus filtrate were given, with only slight decrease of pain. The initial dose was 0.05 cubic centimeters, the last and largest dose was 0.5 cubic centimeters.

Nine intravenous injections of typhoid vaccine with the initial dose of ten million, and the final dose of five hundred million. After the first injection the temperature rose to 101.6 degrees Fahrenheit; this was the highest elevation during the course. The second I. V. injection of vaccine was always given within half an hour after the primary rise; injections were given every other day. After the eighth injection the fetal heart became irregular and weak in quality; when this irregularity was again repeated after the ninth treatment, it was deemed advisable to stop the vaccine medication. The clinical response to this form of therapy was disappointing.

Six roentgen-ray treatments to the shoulders, elbows, and wrists were given before the patient delivered. Total dosage to each of the three mentioned areas was 450 r. When the patient returned to the ward after each exposure, she would always comment on the marked decrease of pain, and she stated, when she left the hospital, that the x-ray treatments had given her more relief than any other measure.

After the first eight days of her hospital stay, the swinging temperature dropped to a normal level and did not rise again until the intravenous typhoid vaccine therapy was administered.

Spontaneous labor pains began at 7:30 a. m., and at 10:14 p. m. of the same day, October 26, 1935, she spontaneously delivered a normal female baby. The patient was unable to use her arms to assist herself during the second stage of labor, and it was necessary to keep her under heavy pentobarbital sedation to relieve the arthritic pain in the arms, which was augmented by the labor pains. The female baby showed no congenital defects. Especial attention was paid to the eyes and the vagina, to prevent a contact gonorrheal infection.

Course.—During the third, fifth, and sixth days postpartum, she ran a slight fever; the highest point being 100 degrees Fahrenheit on the third day, after which time the slight temperature rather quickly returned to a normal level. Although she lost very little blood during the delivery, estimated at 250 cubic centimeters, the blood picture, postpartum, showed the following changes:

October 27, 1935—Hemoglobin, 75 per cent (Sahli); red blood cells, 3,500,000; white blood cells, 7,900.

October 30, 1935—Hemoglobin, 55 per cent (Sahli); red blood cells, 2,250,000; white blood cells, 6,600.

November 5, 1935—Hemoglobin, 55 per cent (Sahli); red blood cells, 3,600,000; white blood cells, 7,600.

A transfusion of whole blood was started, but the patient complained so bitterly (ankle vessel had to be used) that the transfusion was terminated after 100 cubic centimeters had been run in.

After a five weeks' convalescence, she was discharged to the University of California Out-Patient Clinic for physiotherapy and for anti-gonorrheal treatment. On discharge she still presented some moderate restriction of movement of the left elbow and wrist, but the right arm had full and free motion; her general condition was fair; mental state was excellent. The uterus was found to be in a third degree retrodisplaced position and quite painful to move. The

hemoglobin content was only 55 per cent (Sahli), and the red cell count was 3,600,000.

SUMMARY

Presenting a few facts and ideas relative to the diagnosis and treatment of acute gonorrheal arthritis complicating pregnancy.

A successful outcome for the mother and child is dependent on the drastic modification of modern medical therapeutics. The presence of a fetus excludes several of our most efficient measures from the course of treatment. Especial emphasis is directed to the narrow margin of safety in relation to the use of medicinal and hyperthermic procedures when confronted by this rather rare disease condition.

A recent case report is presented for illustration.

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DISCUSSION

Karl L. Schaupp, M.D. (490 Post Street, San Francisco).—Acute gonorrheal arthritis complicating pregnancy is so rare that, in eighteen years at the San Francisco Hospital, the patient described by Doctor Upton is the only one I know to have been admitted for that condition. Personally, I have never had the opportunity to treat such a patient.

The patients that we see more often are those who flare up postpartum where there is not the complicating factor

of a living fetus. I believe the use of hyperpyrexia as a means of treatment to be dangerous to the fetus, as is shown by the number of premature labors with a high fetal mortality rate in patients who are suffering from pyelitis or other conditions with which high temperatures are associated.

Doctor Upton's discussion mentions the many patients who are known to have local infection, as shown by positive smears at some time during the prenatal period. It reminds us again of the need of vigorous treatment of all these patients, so that the local condition may be cleared up before there is systemic invasion.

*

Frances Baker, M.D. (University of California Hospital, San Francisco).—It is very gratifying to read such a paper as this in which the subject is so carefully approached from every angle. There are a few points, however, upon which I wish to enlarge slightly, or to emphasize.

Nature does immobilize involved joints, the muscles contracting into marked spasm where pain is acute. Usually, however, the position assumed is bad. The shoulder is adducted, being held close to the side so that abduction and rotation are very difficult to obtain. If the shoulder is splinted in abduction at 80 to 90 degrees, with some external rotation, movement is much easier to obtain as pain decreases and pain is less where spasm can be relieved. The elbow is usually held flexed and pronated. If it fuses in this position, it is of little value; whereas even a stiff elbow held at 90 degrees in midposition between pronation and supination is valuable. A patient holds the wrist in palmar flexion, while dorsiflexion is necessary for grasp. Hips and knees will be flexed and feet extended, if permitted to remain in positions of comfort, while traction and splinting relieve strain and place joints in positions of least deformity.

This orthopedic care is necessary and must be done early and not left, as Doctor Upton has quoted Harrison[46] as saying, "until the last." Orthopedic care can be carried on while search for infection is being made, and while the blood stream is being sterilized.

I am glad that Doctor Upton has stressed the point that short-wave diathermy is not without danger. Diathermy is of value, but it is not a cure-all, as many seem led to believe. There is no point in using diathermy when radiant heat is as effective or even more so. It should never be used where there may be hemorrhage, as in pregnancy, during the menstrual period, where ulceration exists, etc. Diathermy is a valuable asset, but must be used as carefully as one does potent chemicals.

*

William Benbow Thompson, M.D. (803 Wilshire Medical Building, Los Angeles).—It is extremely difficult to add anything of value to the excellent summarization concerning the treatment of gonorrheal arthritis.

Unfortunately, the addition of pregnancy largely prevents the use of the various hyperthermia methods, since the maintenance of fever would probably destroy the pregnancy and, with the casting off of the dead fetus, open an avenue through which the organism could progress into the uterus and its appendages. It is possible that the judicious employment of hydrothermia might give satisfactory results, especially since Pettit has recently pointed out that sterilization of the active focus can be effected almost as certainly with repeated small febrile reactions as with the prolonged temperature elevations obtained in electrical cabinets. This is, however, no more than a conjecture and, since Upton has so clearly evaluated the beneficial results of other agents, it would seem inexpedient for the present to attempt other than the therapy outlined. Fortunately, the combination of pregnancy and gonorrheal arthritis is extremely rare. With a satisfactory result obtainable by one mode of treatment, there is little justification for experimentation unless this be well within the bounds of safety.

In my opinion, the only agent which should be subjected to further investigation is the effect of sulfanilamid, and for that reason alone I might wish that Doctor Upton would have further opportunity for study of this perplexing problem.

THROMBOCYTOPENIC PURPURA HEMORRHAGICA*

BLOOD STUDIES DURING INFECTIONS AFTER SPLENECTOMY FOR THROMBOCYTOPENIC PURPURA HEMORRHAGICA (INFECTIOUS ORIGIN)

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Discussion *by T. S. Kimball, M. D., Glendale; Robert E. Ramsay, M. D., Pasadena.*

BLOOD studies before and after removal of the spleen have been made by a large number of investigators, but the literature fails to reveal blood studies during infections after splenectomy for thrombocytopenic purpura hemorrhagica (hemorrhagic thrombopenia). However, the relation of the spleen to the defense mechanism of the body against infection is not a new idea. The spleen has long been known as the possible chief organ of the body's immunological forces. Giffin and Holloway,[1] McLean et al.,[2] and others, have called attention to the frequent occurrence of infections, both before and accompanying the onset of thrombocytopenic purpura. That fatal infections occur after splenectomy has been shown by many writers; for instance, one of Wollstein's[3] patients ("N. V.") died of a pneumococcic meningitis sixteen months after splenectomy. It is my purpose to call attention to the infections occurring after splenectomy, and particularly to the changes seen in the cellular elements of the blood in a case of thrombocytopenic purpura.

REPORT OF CASE

G. S., a boy, five and one-half years old, complained, on January 9, 1935, of a sore throat. His mother thought he had fever. He went back to school in three days. Past history up to this time was negative.

The sore throat and fever returned on January 15, and the cervical lymph glands became markedly enlarged and tender. When his physician was called, on the 18th, he had also developed a bright-red macular rash over the face, neck, and thorax, which soon spread over the whole body and then rapidly disappeared. No peeling of the skin followed the disappearance of the rash. His temperature ranged from 102 to 104 degrees. The condition subsided in several days, and he was up and around the house on the 28th.

He then developed, on February 2, a left otitis media. Permission to do a paracentesis was refused until the 6th. Following the paracentesis, improvement was continuous until February 9, when he had a severe epistaxis, and another on the next day. Purpuric spots were found on the skin overlying the sternum on the 11th. Thereupon he was moved to the hospital.

The temperature was 102.6; pulse 120; and within the next twelve hours the purpuric spots had appeared over the whole body. The epistaxis continued. Blood examinations showed 3,000,000 red cells; 60 per cent hemoglobin; 10,300 white cells with 82 per cent neutrophils, 13 per cent lymphocytes, and 5 per cent large mononuclears. The platelet count was 122,000; coagulation time was nine minutes; clot retraction in five and one-half hours; and the fragility test was maximum at 0.38 per cent, and minimum at 0.34 per cent.

A diagnosis was made of symptomatic purpura hemorrhagica.

* From the Department of Medicine of the College of Medical Evangelists, Loma Linda and Los Angeles.

TABLE 1.—*Notes Concerning the Erythrocytes of Patient Herein Reported*

Date	Achromia	Basophilia	Polychromatic Stippling	Normoblasts Per 100 White Blood Cells	Cabot's Rings
February 19, 1935	++++	++++	++++	5	Many
February 20, 1935	++++	++++	++++		
February 22, 1935	++++	++++	++++	2	Few
February 23, 1935	+++	+++		2	
February 25, 1935				3	
February 28, 1935	++++	++++	++++	2	
March 1, 1935	+++	+++			
March 2, 1935				1	
March 3, 1935				0	
March 4, 1935	+++	+++	+++	1	
March 7, 1935	++	++	++	0	
March 9, 1935	No change in red blood cells				
March 12, 1935	No change in red blood cells				
March 18, 1935			++++		
March 20, 1935	Slightly improved red blood cells				
March 25, 1935	+	+	+ Marked improvement		

February 3–4, 1936, slight achromia and basophilia. Occasional normoblast. No Cabot's rings.

The subsequent course was critical. Blood cultures taken later were positive for Staphylococcus albus on repeated examinations. X-rays of the left mastoid region were cloudy. However, after repeated blood transfusions, and other treatment, he was greatly improved by March 9. The purpuric spots had entirely disappeared. All bleeding had stopped, and the platelet count had climbed to 368,000. The blood transfusions were discontinued, largely because of the lack of suitable donors. Immediately after discontinuing the transfusions, the platelet count began to drop, and had reached the low level of 66,000 by March 14. There was no further bleeding, however. His spleen was removed on the 19th. He recovered from the operation without complications, and went home by ambulance on the 21st with a platelet count of 446,000.

His tonsils were infected, and they were removed on April 25. Following this operation, he got along excellently through the summer, except for slight trouble with a chronic sinusitis, and was able to return to school in the fall.

In December, 1935, he again had a left otitis media, from which he recovered after a paracentesis had been done. But on January 19, 1936, he had another attack from which he did not recover after a paracentesis, but which definitely developed into an acute mastoiditis. Mastoidectomy was done on the 29th. Immediately following this operation he was very seriously ill for a while, but later gradually improved until February 8, when he developed trouble in the right chest, which proved to be an empyema. This was treated by closed drainage. As he was recovering, following the mastoidectomy and the empyema, on March 14 he developed an acute appendicitis. Appendectomy was done. Following this, his convalescence was without further complications, and he was dismissed from the hospital on April 1, 1936. When last seen, in September of this year, he was in very good condition, having gained in weight, and was looking fine. Roentgenograms of his chest showed the empyema to have completely healed.

Most of the blood findings have not been given above, as they are shown in the various charts in relation to his different infections. It was of interest that Cabot's rings in the red cell were seen before splenectomy, and none thereafter. Nucleated erythrocytes were present during the anemia periods, as shown in the accompanying charts.

COMMENT

As has already been mentioned, McLean [2] reported twenty-one cases of purpura in children, twelve patients giving a definite history of recent infection preceding the onset of hemorrhages. Nine of these had upper respiratory infections and six preceded the onset by a few days. It is of interest that his patient, who died on the twenty-fifth postoperative day, failed to show a rise in the blood platelet count.

It was Frank [4] who showed that there was a group of purpura cases which had low blood platelet counts. Kaznelson [5] demonstrated, in 1916, that splenectomy had a remarkably beneficial effect on those cases of purpura that had previously been shown by Frank to have a low blood platelet count. This stimulated considerable interest in this phase of the spleen problem. The rise in the platelet count has been found by all observers, both experimentally [6] and clinically, [7] though the evidence varies as to the duration of the increase. Krumbhaar [8] has demonstrated that the removal of the normal mammalian spleen causes a true, mild anemia, the appearance of nucleated red cells, and an increase in reticulocytes and in platelets. The latter begins about the sixth to eighth postsplenectomy day. Wollstein [3] did not find anemia in their splenectomy cases of thrombocytopenic purpura. A number of investigators [9] have pointed out that the rise in the platelets begins immediately [10] after the removal of the spleen in thrombocytopenic purpura patients, and the increase reaches a maximum in three to ten days. A million to over a million and a half platelets per cubic millimeter have frequently been reported, and the increased level is maintained at from 600,000 to 900,000 for many months. Dawburn, [7] Hueck, [11] and Shore [7] have shown that a rise

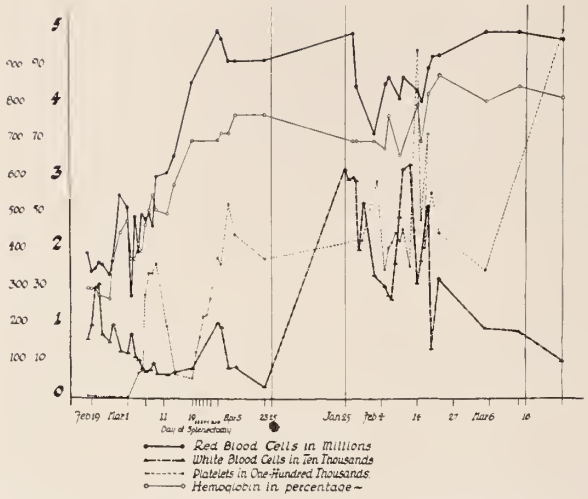


Fig. 1.—Graph showing changes in the formed elements of the blood just before and following splenectomy.

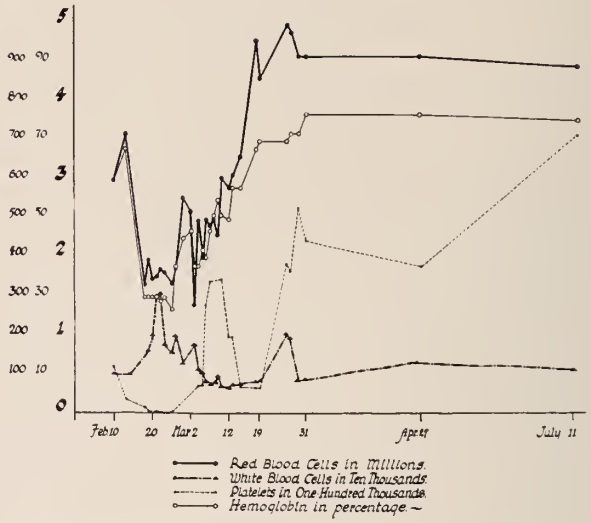


Fig. 2.—Graph showing the changes in the blood cells and hemoglobin during infections about one year after splenectomy.

in platelets about the sixth to eighth postoperative day occurs after any surgical operation with an equal amount of trauma to the tissues as occurs in a splenectomy operation.

Holloway and Blackford,[7] Cari,[12] and Galloway [7] have demonsrated a lowered platelet count in the splenic vein, as compared with that of the peripheral veins, capillaries and splenic artery; this, however, has not always been demonstrated. Holloway [7] has reported the blood platelet count of the splenic vein is not normally below that of the splenic artery, but is usually slightly elevated above that of the arterial blood. This all is in support of the theory that the etiologic agent of "hemorrhagic thrombopenia" (McLean) is in some way related to an infectious process. Giffin [1] suggests that it is a toxic material from an infectious process which rapidly destroys platelets. "The toxin affecting these changes is perhaps a secondary substance; the production of which is initiated by the pathological process; possibly some abortive substance originally designed to protect," he says.

Naegeli [13] found that lymphocytosis is a constant sequel to the spleen. Wollstein [3] and others have noted an eosinophilia. There have been no satisfactory explanations for either one of these.

RÔLE OF THE SPLEEN

All of these facts point to the spleen as a center for platelet destruction, a chief immunological organ; and, possibly, a factor in the maturation of the red blood cells and in the control of the lymphocytes in the peripheral blood. Our knowledge of the latter two is at present very meager, and certainly far from settled. What the essential change or pathologic process is in the spleen that makes it destroy excessively large quantities of platelets (or in some way alter their useful nature), and what causes the increased permeability or fragility of the capillaries, all of which occur in purpura, still remain problematical. However, the case herein reported does suggest that the spleen is probably: (*a*) an organ of defense against infections; (*b*) it apparently controls the number of platelets in the circulating blood, both in "time of peace and in times of infection."

It is evident that the diagnosis of the case herein reported was erroneous, for it was definitely of infectious origin. However, the observations following splenectomy are interesting and tend to substantiate the above observations in that the platelet count increased immediately upon removal of the spleen (Figs. 1 and 3). It was also interesting to see the relation between each new infection, particularly the severity of the infection, and the platelet count. The platelets increased or decreased with each rise or fall in the white cell count, and with an equal clinically evident increase or abatement in the severity of an infection. There was, however, a lag of about twenty-four to forty-eight hours in the increase or decrease of the platelet count in respect to the leukocytes, as is shown in Fig. 2. This close relationship of the platelets to the leukocytes is evident even when one has considered the trauma of the operations performed on this patient, and the blood transfusions given him. Anemia was mild, but not of sufficient prominence to corroborate Krumbhaar's findings of anemia in splenectomized mammalians. However, nucleated red cells and Sabot's rings in red cells were seen before the splenectomy was done; the nucleated erythrocytes appeared apparently because of the anemia, as they reappeared with the anemia accompanying the postsplenectomy infections and have disappeared again now that he is apparently in good health. The mild eosinophilia reported by several authors was not encountered in this case. Our patient is keeping a high platelet count in the peripheral blood. This may be in part due to our laboratory's method of determining the platelet count: they are made on venous blood, and we have found our determinations to be about 50,000 higher than those taken from capillary punctures.

We have been of the opinion that, from the standpoint of infection, this patient was done more harm by the splenectomy than if he had received only

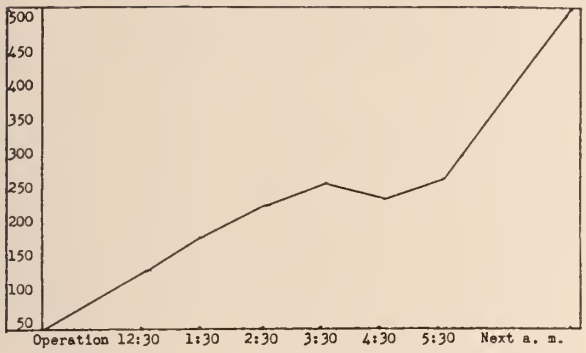


Fig. 3.—Showing rise in blood platelets immediately following splenectomy.

blood transfusions; since his purpura was probably of infectious origin.

SUMMARY

1. A case of thrombocytopenic purpura hemorrhagica, infectious origin, in a five and one-half year old male, has been reported. Splenectomy was performed, which resulted in the expected rise in platelets and cessation of hemorrhages. In the year following this, the patient suffered several severe infections, during which blood studies showed a close relationship between the platelets and the leukocyte counts.

2. The literature pertaining to infections and blood-cell findings, before and after splenectomy in hemorrhagic thrombopenia, has been reviewed.

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DISCUSSION

T. S. Kimball, M.D. (217 North Central Avenue, Glendale).—The case reported by Doctor Abbott is most interesting from a hematological point of view. I believe this case well illustrates what hematologists very often find but seldom report. Most cases of thrombocytopenic purpura are precipitated by acute infections, drugs, exposure or some other harmful agent, but the mechanism of platelet destruction is not understood at all. It has been a well-known fact that removal of the spleen in most cases causes an abrupt and marked rise in the number of platelets. On several occasions we have seen, at the Los Angeles County Hospital, cases following splenectomy which showed spontaneous reduction in platelet counts during acute infections. It is also a well-known fact that, following a splenectomy, there is hyperplasia of the so-called reticulo-endothelial deposits in other parts of the body, and probably they function in much the same manner as the spleen if it were present.

No paper on this subject would be complete without mention of the excellent results obtained with the use of deep x-ray therapy over the spleen. This is much safer than splenectomy and seems to have all the benefits of that operation.

❋

Robert E. Ramsey, M.D. (65 North Madison Avenue, Pasadena).—From the clinical symptoms and positive blood cultures, we may assume that the patient had a bacteremia. It is possible to explain his purpura as a manifestation of toxemia affecting bone marrow, spleen, and the permeability of blood vessels. It is noteworthy that hemorrhage had stopped before splenectomy was performed. It is, therefore, seriously to be doubted whether a platelet count of 60,000 was low enough to warrant splenectomy. The ability of this patient to surmount such an array of complications as later followed is remarkable, spleen or no spleen, and, to my mind, supports the supposition of foci of infection based on the original condition. The present condition of the patient indicates recovery from infection due to the eradication of active foci, but is no assurance of freedom from subsequent infection.

THROMBOCYTOPENIC PURPURA HEMORRHAGICA*

TREATMENT WITH MASSIVE DOSES OF MOCCASIN SNAKE VENOM

By Carlyle P. Imerman, M.D.
AND
Stanley W. Imerman, M.D.
Los Angeles

Discussion *by Ernest H. Falconer, M. D., San Francisco; Cyrus C. Sturgis, M. D., Ann Arbor; V. R. Mason, M. D., Los Angeles.*

In 1928, Shwartzman[1] described a phenomenon of skin reactivity (local hemorrhagic necrosis) to bacterial filtrates, which was produced when intradermal injections of these filtrates were followed at suitable intervals by intravenous injections. The use of moccasin snake venom in the treatment of hemorrhage was based on the experiments of Peck and Sobotka[2] in 1931. They demonstrated that if a period of from fourteen days to one month was allowed to elapse after the injection of rabbits with moccasin snake venom, a large number of the animals became refractory to the Shwartzman phe-

* Read before the General Medicine Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

nomenon. In 1932, Peck[3] made an attempt to treat various hemorrhagic conditions with moccasin snake venom, and this clinical trial included five cases of thrombocytopenic purpura which exhibited such symptoms as epistaxis, purpura, and prolonged and profuse menstrual periods. All of these cases showed definite clinical improvement.

The following case is presented to demonstrate the remarkable effect of massive doses of moccasin snake venom administered to a patient with thrombocytopenic purpura hemorrhagica, after the usual standard doses and blood transfusions had failed.

REPORT OF CASE

Male, age forty-seven years, complained of bleeding from the gums, purpuric spots under the skin and mucous membranes of the mouth, malaise, bloody urine, and tarry stools for a period of eight days. There was no family history of hemorrhagic diathesis. A tonsillectomy was performed in 1930 without any unusual bleeding. Physical examination on September 3, 1936, revealed: temperature 100.6 degrees, pulse 120 per minute, respiration 28 per minute. The patient was well nourished. The skin was very pale and there were numerous purpuric spots over the entire body, and buccal mucous membranes. The teeth were carious, and the gums presented marked pyorrhea and profuse hemorrhage. The tonsils were absent. Heart and lungs were normal. Liver and spleen were not enlarged. The blood pressure was 100/60, and after the cuff was allowed to remain inflated for five minutes numerous ecchymoses were noted in the forearm below the cuff. The urine showed a heavy trace of albumin and a macroscopic hematuria.

The blood examination revealed a marked secondary anemia, hemoglobin 57 per cent, erythrocytes 2,930,000, color index .97, leukocytes 10,800, and a normal differential. Stained smear showed a slight anisocytosis, and a few cells showed polychromatophilia, and stippling, and evidence of toxic changes. Platelet count was 18,000 per cubic millimeter. Bleeding time was five minutes, coagulation time two and one-half minutes, and the clot showed nonretractility. Fragility test was normal. The prognostic venom reaction[4] elicited by the intradermal injection of 0.1 cubic centimeter of 1:3000 standardized moccasin snake venom, with a control of 0.1 cubic centimeter of physiologic solution of sodium chlorid, showed a positive capillary rupture with diffusion of blood into the tissues in one hour. Blood chemical examination of the stools was strongly positive.

Therapy consisted of three subcutaneous injections of .3, .5, and 1 cubic centimeter, respectively, of moccasin snake venom, three whole-blood transfusions of 500 cubic centimeters each, and two intramuscular injections of 20 cubic centimeters each of patient's own blood. In spite of this treatment, the patient's general condition became worse, bleeding from the gums became more profuse, and the platelet count dropped to 12,000 per cubic millimeter, hemoglobin 56 per cent, and erythrocytes 2,100,000. On September 9, 1936, under general anesthesia, the carious teeth were extracted and the necrotic gum tissue was removed. A transfusion of 500 cubic centimeters of whole blood was given, and two hours later the patient went into shock; pulse 160, temperature 96 degrees, and blood pressure 80/60, and the hemorrhage from the gums was enormous. At this time a 5 cubic centimeter dose of moccasin snake venom was given subcutaneously and the gums were tightly packed. Within twenty-four hours the gingival bleeding stopped completely, the platelet count rose to 18,660, and the patient's general condition improved remarkably. Subsequent therapy consisted of a one cubic centimeter dose of snake venom on September 13, 1936, a whole-blood transfusion of 500 cubic centimeters on September 14, 1936, three doses of 3 cubic centimeters each of intramuscular liver extract, and reduced iron grains seven and one-half three times daily orally. The platelet count rose steadily to 231,000 per cubic millimeter on the fourth day after the massive 5 cubic centimeter dose was given, and the purpuric spots on the skin and buccal mucous membranes had completely disappeared, the urine showed no red blood cells and the stool was negative for occult blood. On the sixth day the platelet count was 302,000 per cubic millimeter, hemoglobin was 62 per cent, and red blood cells 3,560,000. On the eighth day the prognostic venom reaction was negative and the patient was discharged from the hospital. The patient was seen at subsequent intervals of every two weeks up to February 4, 1937. He was given a two cubic centimeter dose of moccasin snake venom and a one cubic centimeter dose of intramuscular liver extract on each occasion. On November 2, 1936, and November 16, 1936, the remaining teeth were extracted under general anesthesia, and there was a prompt cessation of bleeding on each occasion in about two minutes. Darkfield showed positive Vincent's spirillae and bacilli. The platelet count varied between 220,000 and 333,000. On February 4, 1937, the hemoglobin rose to 88 per cent and red blood cells to 4,700,000. Bleeding time was one minute, coagulation time four and one-quarter minutes, and the prognostic venom reaction was negative.

COMMENT

1. This is a case of severe thrombocytopenic purpura hemorrhagica which may have been caused by carious and abscessed teeth, extreme pyorrhea alveolaris, and Vincent's angina.

2. The patient's general condition and blood picture became worse following the administration of the usual maximum standard doses of one cubic centimeter of moccasin snake venom, as suggested by Peck and Rosenthal,[5] transfusions of whole blood and intramuscular injections of whole blood.

3. It is plausible that the prompt cessation of bleeding, which occurred in twenty-four hours, and the marked hematological and clinical improvement, which occurred in four days, was due to the subcutaneous injection of a massive 5 cubic centimeter dose of moccasin snake venom. It is entirely possible that large doses may accomplish spectacular results after smaller doses have failed, in view of the fact that the platelet count dropped, and bleeding became more profuse after three blood transfusions and three relatively small injections of snake venom. Although one cannot eliminate the fact that the platelets may normally fluctuate greatly, Sturgis[6] states that he cannot recall that he has ever seen the platelet count spontaneously increase as rapidly in any patient in a period of four days.

4. The theory that moccasin snake venom achieves its results by acting directly on the blood vessels is substantiated by the experiments of Peck[3] in 1932. This viewpoint is strengthened when one considers the fact that there was marked beneficial effect on the tendency to hemorrhage in cases with varied etiological factors, such as idiopathic epistaxis,[3,5,7] functional uterine bleeding,[3,5] toxic, anaphylactic, and endocrinal purpura,[3,5] multiple hereditary telangiectases,[3,5] and in those cases of thrombocytopenic purpura hemorrhagica in which the platelet count did not rise appreciably.[3,5] Peck and Rosenthal[5] stated that the severity of the disease does not depend on the number of platelets, but more likely on the fundamental principles, such as a functional qualitative capacity of the capillaries either in their contractile function or the character of their wall. Furthermore, certain patients following splenectomy[8] have failed to show subsequent hemorrhage even though the platelet count returned to its previous low level. However, in spite of these facts, it is possible that even though relatively small doses do not induce any definite change in the blood picture, large doses may cause an increase in platelets and thereby

hasten recovery in those cases in which there is a deficiency in regeneration of capillary walls.

5. It is well to bear in mind that there are no contraindications to the use of moccasin snake venom. A hypersensitive individual may be desensitized according to the method of Peck and Rosenthal,[5] and exacerbations of the underlying conditions do not occur. Furthermore, this massive dose was given during a period of acute shock, and demonstrates that it can be given safely even under the most unfavorable conditions.

SUMMARY

1. This patient received the largest dose of moccasin snake venom that has been reported in the literature.

2. This massive 5 cubic centimeter dose was given during shock, without any danger to the patient, and was followed by prompt, rapid, clinical and hematological recovery.

3. The rapid response and beneficial effect to the patient which occurred in four days cannot be explained on the basis of a spontaneous remission. It cannot be stated whether large doses affect the capillary walls directly or whether the cure was due to the platelet regeneration.

4. Massive doses should be tried in those cases that are refractive to the usual therapeutic measures, and before any surgical procedure as formidable as splenectomy is contemplated.

5. The importance of the removal of all foci of infection, in spite of the bleeding tendency, is again emphasized.

6. The results of one case are not conclusive, but it is hoped that further cases will occur to substantiate our observations that the suggested doses of moccasin snake venom are inadequate in certain cases.

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DISCUSSION

Ernest H. Falconer, M.D. (384 Post Street, San Francisco).—To those of us interested in testing the therapeutic effects of moccasin-snake venom in thrombocytopenic purpura hemorrhagica, this report of Doctors Carlyle and Stanley Imerman furnishes food for thought. In our use of the venom at the University of California Hematology Clinic, we have considered any favorable results that have occurred as due to tonic effects of the venom on the capillaries. We have not found any significant increase in blood platelets following its use. Our dosage, however, has been even smaller than the recommended dose of one cubic centimeter. One serious constitutional and local reaction following the use of one-half cubic centimeter of moccasin venom has made us, perhaps, overly cautious in its use. The striking increase in platelets in the above reported case, therefore, certainly merits further investigation, particularly from the experimental side.

❦

Cyrus C. Sturgis, M.D. (University of Michigan Medical School, Ann Arbor).—The Doctors Imerman paper is of great interest to me, as it must be to anyone who has been confronted with the difficulty of managing patients with purpura who are bleeding extensively. I have always advised repeated transfusions as the procedure which is least harmful and the most likely to benefit the patient. It must be admitted, however, that this does not always control the bleeding. While splenectomy may accomplish remarkable improvement, it should be attempted only after all other measures fail. This is because it is a radical operation in a bleeding patient, and because it is not possible to predict, in any given case, that improvement will result.

I have used moccasin-snake venom, but without striking success. It deserves more consideration and further trial. It is possible that, if a larger dose had been used, as in Doctor Imerman's patient, better results might have been obtained.

❦

V. R. Mason, M.D. (838 Pacific Mutual Building, Los Angeles).—The report of a single instance of a rare disease treated by very large doses of a remedy whose pharmacological properties are not well known is of importance in urging others to do likewise with wisdom. However, in dealing with purpura of the thrombocytopenic type, it should be kept clearly in mind that the differentiation between the essential and symptomatic types may be extremely difficult or impossible even after the patient has been kept under observation for many months. The confusion in the literature regarding the efficacy of various therapeutic procedures is produced by incomplete temporal observation and by failure to distinguish between symptomatic relief and cure. In my experience with thrombocytopenic purpuric states, startling results, both good and bad, have been frequent and usually unexpected.

The case reported here probably should be classified as an example of a symptomatic thrombocytopenic purpura hemorrhagica, in which the snake venom tided the patient over the spectacular, but statistically not very dangerous, period of acute hemorrhagic manifestations.

ENDOCRINE THERAPY IN ACNE VULGARIS*

By H. J. Templeton, M.D.
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Discussion *by Hans Lisser, M.D., San Francisco; Stanley O. Chambers, M.D., Los Angeles; Laurence R. Taussig, M.D., San Francisco.*

IT has always been a common belief among physicians that there is some relationship between acne vulgaris and the functioning, or dysfunctioning, of the endocrine glands. This belief is based upon certain well-established clinical observations, namely, that the onset of acne nearly always coincides with the onset of puberty, that an extremely high percentage of young girls will develop a few

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acne lesions, or suffer from an exacerbation of their acne, at their menstrual periods, and that there is a tendency for acne to retrogress after puberty and during early married life.

EARLIER DAYS OF ENDOCRINE THERAPY

In the earlier days of endocrine therapy, a number of clinicians treated acne by means of the oral administration of the products then available, such as thyroid, ovarian, testicular, and adrenal extracts. Their results were so uniformly discouraging that it is unnecessary to review the bibliography. Following these discouraging reports, endocrine therapy of acne fell into disuse. It was but natural, however, that when modern methods of determining sex-gland activity were developed, and when accurately standardized, physiologically potent extracts became available, physicians should again turn their attention to this type of treatment.

LATER METHODS

Inasmuch as it is possible to accurately measure the amount of estrogenic substance in the urine of female patients, it would seem logical to compare the amounts present in the urine of acne patients with the amounts present in the urine of normal controls. Then if a deficiency were found in the acne group, they could be treated by means of injections of accurately standardized estrogenic substance. Reasoning along such lines, Rosenthal and Kurzrock [1] determined the amount of estrogenic substance in the urine of patients with acne. Estrogenic substances should be normally present in the urine of all women during their active sex life. These workers found that it was absent in twenty-seven, normal in six, and in a small quantity in one. No gonadtropic substance was demonstrated in any of these urines. Rosenthal [2] then treated a series of thirty-eight acne patients by injections of estrogenic substance. Of these, thirteen patients definitely improved, ten showed slight improvement, and fifteen failed to improve. Van Studdiford [3] treated fifteen patients with estrogenic substance and reported that eleven of them improved. He treated another series of sixteen patients with a gonadtropic substance given postmenstrually, along with estrogenic substance given premenstrually. Eight of these patients improved. Lawrence [4] treated thirty patients (ten males and twenty females) with a gonadtropic substance (antuitrin "S"). Ten of these patients were cured, eleven were much improved, while seven showed only moderate improvement.

OTHER REPORTS

The above reports give the brighter side of the picture. Less encouraging results were reported by Michael,[5] who stated: ". . . twenty-six females have received what may be considered as reasonably good opotherapy . . . the therapeutic results have been poor and discouraging." It should be noted that Michael was working along with a gynecologist in order to determine the type of endocrine needed by each patient, and that these were modern products.

McCarthy [6] treated a large series of patients with modern hormone preparations such as antuitrin "S" and theelin. He concluded, "hormonal therapy is of no value in acne vulgaris except in the recurrent papulopustular types that have been previously treated with sufficient x-ray."

AUTHOR'S SERIES

Group A:

Seventeen college students—nine boys and eight girls—constituted one series. They presented acne vulgaris of various degrees of severity. Most of them had been treated previously with various local applications. Several had had x-ray, and/or ultraviolet light, and/or estrogenic substance, and had not responded favorably.

Photographs were taken of most of the patients before treatment was begun, in order to establish a base line for future comparison. Then 200 rat units of anterior pituitary-like substance of pregnancy urine (antuitrin "S")* was injected three times a week. Absolutely no other treatment, either local or general, was given. The injections were given over periods of six to eighteen weeks, for an average of ten weeks.

Ten of the group showed no improvement. Of the seven who improved, none were completely cured; four improved 33 per cent; one improved 50 per cent, and two improved 66 per cent.

In those showing improvement there was no correlation between length of treatment and improvement, except that most of the improvement seemed to take place in the first three or four weeks of treatment.

Those patients who showed no improvement were treated as follows: twelve weeks, one; eleven weeks, three; ten weeks, one; nine weeks, two; eight weeks, two; seven weeks, one.

Group B:

Another series of twenty-two patients, all female college students, was treated by injections of estrogenic substance (amniotin)† and 2000 international units were given at approximately weekly intervals. An average of nine injections were given each patient, the number varying from six to nineteen injections.

Eleven of the group showed no improvement. Of the eleven who improved, none were completely cured; two improved 33 per cent; five improved 50 per cent; and two improved 66 per cent.

A clinical impression that we gained while observing those patients treated with antuitrin "S" was that there was a certain indefinable improvement in the texture of the skin of a number of the patients. This somewhat resembled the softening in skin texture seen in hypothyroid patients when they are given thyroid.

COMMENT

Although a certain number of these patients showed improvement, the results were certainly far inferior to orthodox dermatologic-roentgen

* Furnished through the courtesy of Parke, Davis & Co.
† Furnished through the courtesy of E. R. Squibb and Sons.

therapy. And yet, the improvement which did result encourages us in our belief that acne is related to the endocrine system, and that further experiments with endocrine therapy are in order.

However, when only 50 per cent or less show any improvement and none show complete remission, the physician who undertakes the treatment of an individual with anterior pituitary-like substance of pregnancy urine or estrogenic substance is promising less chance of cure than the average patient is willing to take. Until it is possible to determine which gland preparation to use, which patient will respond, and how much to give, it would seem wise to refer endocrine therapy in acne back to the field of research problems.

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DISCUSSION

HANS LISSER, M.D. (384 Post Street, San Francisco).—Naturally, I am in entire agreement with Doctor Templeton in his postulation of the theory that, in all likelihood, there is an endocrine background for acne. Its almost invariable appearance at puberty, and its continuance for a varying number of years thereafter, are suggestive evidence of such a relationship. It is also pertinent and interesting that in cases of sexual precocity, where adult sex characters appear in the first few years of life, acne likewise accompanies this. It has also been noted that adult women who, let us say, have been menstruating normally and who had not suffered from acne, and who in their thirties develop Cushing's syndrome with amenorrhea, heterosexual hypertrichosis, obesity, hypertension, etc., acne makes its appearance with this endocrine upheaval. There is, therefore, considerable clinical experience to justify the assumption that acne has endocrine affiliations. The precise relationship, however, remains to be determined. The situation is comparable to migraine which commonly begins at adolescence, and in women, at least, disappears with menopause. One is also reminded of the sudden appearance of dental caries in the 'teen age, despite regular and conscientious dental care all through childhood.

Doctor Templeton deserves credit for having made a clean-cut attempt to evaluate a specific type of endocrine therapy in acne. His results are not particularly favorable. This indicates merely that prolan injections do not solve the endocrine problem of acne. That some other organotherapy might be more effectual remains to be proved.

Acting on the assumption that there is some relationship between ductless gland disturbances and acne, granting that for the present this remains a vague one, I have for many years investigated, from an endocrine standpoint, a great number of boys and girls who have suffered from acne; they do not fit into any single endocrine type or endocrinopathy. Accordingly, I have treated them with the endocrine products they seemed to need in the hope that this would also have a beneficial influence on the acne. My clinical impression of all this can be summed up as follows: that neither endocrine therapy alone, nor dermatological procedures alone, evoke the best results; but that the utilization of both maneuvres, coincidentally, achieve better effects than either alone. However, I must repeat that the endocrine therapy must be individualized for the particular case. In other words, as yet there is no specific endocrine treatment for acne; but coöperation by dermatologist and internist (endocrinologist) is desirable.

STANLEY O. CHAMBERS, M.D. (826 Roosevelt Building, Los Angeles).—From other sources, as well as this rather complete study by Doctor Templeton, it would seem most rational to question the use and effectiveness of endocrine medication in the treatment of acne, regardless of its type. It is, however, difficult not to believe that the endocrine mechanism plays a part in its development. This part which the endocrines play must by quite different from the effect of these agents as we visualize it clinically and in the laboratory today. An increase in skin function would be directly opposed to our present dermatologic efforts, for we feel that the development of the acne papule is the result of a hyperactivity of the cutaneous gland. I believe we have sensed a relation between the disease and the endocrines. In neglecting the two principles which I have just noted, we have tried to utilize an agent in the treatment of acne because of its specificity in affecting the endocrine mechanism in other abnormal states.

With the publication of recent data relative to the effect of endocrine substances on other glandular tissue, and the favoring of malignant tendencies in these tissues, we have further reasons for caution in the use of these substances for the treatment of acne.

If these were partial evidence of specificity, then the assuming of some risk would seem warranted.

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LAURENCE R. TAUSSIG, M. D. (384 Post Street, San Francisco).—Acne vulgaris is one of the most common cutaneous diseases with which we have to deal. It is very distressing to the patient, and the methods of treatment available are far from ideal. The eruption undoubtedly is the result of a combination of factors rather than of some single factor. Furthermore, these factors are not constant, but vary from patient to patient. One important factor is very possibly coupled with the sex hormones. It is noteworthy, however, that eunuchs do not have acne as a rule. Carefully controlled research, such as this, is of distinct value. The only possible criticism is that the dose of antuitrin "S" given was not very large, and the dose of amniotin was quite low. It might be worth while to repeat these series, giving a considerably higher dosage in each group. I am wholly in accord with the author's conclusion that the evidence presented does not warrant the indiscriminate use of these hormones in the treatment of acne.

ROTATING ANODE X-RAY TUBE*

By ROBERT A. POWERS, M.D.
Palo Alto

DISCUSSION *by R. R. Newell, M.D., San Francisco; Robert S. Stone, M.D., San Francisco; L. H. Garland, M.D., San Francisco.*

THE rotating anode x-ray tube was developed to meet the modern demand for a heavy-duty tube with a small focal spot. These observations will consist entirely of a few notes on actual experience with the new tube and reactions thereto. A splendid and complete description of the tube is available in the manufacturer's announcement.† The principle of construction is, of course, familiar to all radiologists, and will not be discussed here.

* Read before the Radiology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

† The General Electric X-Ray Corporation. The foreign "Rotalix" tube, manufactured by Phillips, is not herein discussed.

Essentially the tube is shock-proof, oil-immersed, and has two focal spots of the amazing size of one and two millimeters.

ADVANTAGES OF THE TUBE

A tube with a two-millimeter focal spot, capable of delivering 500 ma. at 80 KVP for one-thirtieth second, excites the imagination of the radiologist, and opens up new vistas as to the future possibilities in radiological diagnosis. Needless to state, these improvements in diagnosis will be limited to those parts which cannot be adequately immobilized (heart, lungs, abdominal organs), and to children and those patients whose movements cannot be controlled. To discuss some of the advantages of the tube: In lung examinations the high milliamperage available makes possible the use of extremely low kilovoltage resulting in high contrast with increased visibility of small parenchymal densities. In cases of lung consolidation, Bucky diaphragm exposures can be made in a very short time. Lateral chest examinations, even with the Bucky grid, can be made in as little as one-sixth second. Cardiac valve and coronary artery calcifications should be much more easily demonstrated. In filming children's chests the tube is invaluable, especially when using grid technique. Excellent p. a. projections may be obtained in as little as 1/120 second. The tube is especially valuable in children's mastoid examinations. Here the combination of high speed, good contrast, and finest detail is essential and the tube fulfills every demand.

Gastro-intestinal and gall-bladder diagnosis are greatly enhanced, and lateral stomach examinations on the Bucky grid can be made in as little as one-fifth second. On nervous and "jittery" patients, exposure time can be cut to a minimum and motion "stopped." An instance of the tube's value in this type of patient occurred shortly after its arrival. At previous examinations we had found extensive caries, involving one of the vertebra. We were never able to completely immobilize the patient, however, and it was impossible to determine the amount of bone destruction present. Examination with the new tube demonstrated normal bone trabeculae throughout most of the vertebra, whereas previous films had suggested rather extensive disease. Treatment could be planned accordingly. Having used the tube for only a short time, we have barely approached the optimum in technique, but feel that with additional experience and exchange of ideas our roentgenological work will be greatly improved.

LESS DESIRABLE CHARACTERISTICS

Having briefly discussed some of the many advantages of the tube, I will touch on some of the less desirable characteristics, necessary to the type of construction. The tube is quite heavy, weighing fifty-eight to sixty pounds. Average tube stands are inadequate. The stand at present provided by the manufacturer has an insufficient up-and-down range, as the tube can be lowered only to a point 51½ inches above the floor. This is inadequate and makes impossible many routine technical procedures.

The motor in the tube causes a slight vibration which can be felt with the hand. The amount of vibration increases the size of the focal spot, but our tests show this to be negligible. The motor in the tube also makes a moderate amount of noise. As aptly stated by the service man, "It sounds like a kid going down the street on roller skates." This noise is a little disturbing to nervous patients, who may tense-up. In discussing the motor, it should be stated that the manufacturer's instructions state that the total time of rotation should not exceed one minute in any three-minute interval. Also the exposure should not be made until the motor has been in operation one second, but not more than a few seconds. This requires quick work on the part of the technician.

The filament current ranges from 3.5 to 5.7 amperes, requiring recalibration of the average ammeter, which only goes to 5 amperes. The ammeter divisions must be fine, as the slightest deviation may result in an error of 25 to 50 milliamperes. The manufacturer has provided a chart for presetting the ammeter value, or a ballistic meter may be used.

DETERMINATION OF HEAT UNITS

Cooling is a problem in this type construction: 50,000 heat units is the maximum permissible in any five-minute interval. We have determined the number of heat units generated in the various types of routine examination as follows:

Type of Examination	No. of Films	Heat Units
Stereoscopic skull study	8	75,360
Paranasal sinuses	5	65,020
Teeth Fast films	16	27,700
Teeth Radiatized films	16	68,352
Stomach(average)	8	14,702
Grid films(average)	5	16,071
Chest(average)	3	5,592
Spine—lumbar	3	47,720

As a five-minute rest period is required following the storage of 50,000 heat units (or one sinus examination), busy clinics must have another tube unit available during the cooling interval.

TARGET ANGLE

Due to the type of anode construction, the target angle is set at 15 degrees. At the average distance used, this covers a limited area of film. Film areas covered are as follows:

Film Size	Minimum Focal-Film Distance
8 x 10	22½ inches
10 x 12	26 inches
11 x 14	30 inches
14 x 17	36 inches

This is a minor disadvantage, however, as most films may be exposed at 36 inches.

The voltage permissible through the tube is 90 KVP. With the high milliamperage available, however, this appears entirely adequate.

SUMMARY

We have found the new rotating anode x-ray tube a valuable addition to diagnostic x-ray equipment, particularly in the examination of the heart and lungs, children, and nervous patients.

Disadvantages inherent in the type of construction are briefly discussed.

Medico-Dental Building.

DISCUSSION

R. R. Newell, M.D. (Stanford University Hospital, San Francisco).—Phillips Company in Holland has made a successful rotating anode tube for eight years. Only with General Electric Company's announcement of their double-focus, oil-immersed tube, did it become evident that rotating anode would be applicable to all radiography. Doctor Powers is to be congratulated for installing one of these as soon as he could get it.

Doctor Powers' paper well sets forth the advantages of this tube—advantages shared, of course, by the Phillips tube which is now being made in the United States, and is available with double focus. In our experience the work of this tube is so much superior that, for most examinations, one becomes dissatisfied with films made with stationary anode.

The fine focus is the one to use. Very rarely should one choose the two-millimeter focal spot. I am publishing in *Radiology* a discussion of optimum technique for showing detail in the lung field. Even if that means that one must move the tube up to one meter distance, still one should choose the one-millimeter focal spot.

The rotating anode tube is definitely expendable equipment, being good for only about ten thousand exposures. Replacements are costly. But even so, the additional cost per exposure is only about five cents. This is a small fraction of the total cost of the examination, and we ought not to begrudge it, considering the betterment in the radiographs.

Robert S. Stone, M.D. (University of California Hospital, San Francisco).—Doctor Powers has given us a very careful description of the rotating anode tube, showing its advantages and disadvantages. There have been some disadvantages in every x-ray tube so far produced. I think that in the rotating anode tube the disadvantages are less than in any tube previously produced, and the advantages are so much greater than anything before available that they far outweigh the disadvantages. The only objection I have to the rotating anode tube that is in use at the University of California Hospital is that it produces films of such sharpness in detail that films from other tubes seem to be of poor quality, and we are continually blaming the technicians for not getting better films. It is my feeling that just as soon as we are financially able, we will have rotating anode tubes in all of the diagnostic services.

L. H. Garland, M.D. (450 Sutter Street, San Francisco).—The early diagnosis of many diseases depends upon their early detection by the roentgenologist. The finer the detail obtainable in a given set of roentgenograms the more probable it is that early disease will be detected. During the last decade the research departments of film, chemical and equipment manufacturing companies, have given us steadily improving tools with which to detect early disease. We now have excellent high speed, nonscreen x-ray films, fast developer solutions, and high output x-ray equipment. For several years it has been my privilege to use a 1000 milliampere 140 KV diagnostic x-ray unit. The impulse timer designed for this unit permits the use of very short exposures and thereby the satisfactory reproduction of detail in fast-moving regions such as the left lower lobe of the lung and the small bowel. Until recently it was necessary to use a rather large, fixed focal spot with this type of equipment, but, as Doctor Powers has mentioned, with the introduction of the rotating target tube it is now possible to use small focal spots with extremely short exposure times. There is no doubt that the earlier diagnosis of common lesions, such as pulmonary tuberculosis, osteomyelitis, and metastatic carcinoma of bone, will be immensely facilitated by the new tube. It is still somewhat limited in the voltage that can be applied to it, but no doubt this will be improved with time.

In order to utilize the advantages of the small focal spot of the rotating anode tube to the fullest, it is necessary to use nonscreen film. It is well known that intensifying screens obliterate fine detail. Unfortunately, the increase in exposure time necessary in the case of thick patients or thick parts limits the use of nonscreen film to patients weighing less than 140 pounds, or at the present time to thinner portions of the body. (See Files, G. W., *Radiology*, p. 582, November, 1937.) When the speed of nonscreen films has been increased, then physicians possessing both rotating anode tubes and high-speed Buckys will be able to do a quality of general radiographic work which is as good as can now be done with extremities. Nonscreen films can be magnified and almost "microscopic" detail studied in them. The detection of the fine nodulation of early silicosis, the tiny cholesterin calculi of early cholelithiasis and the first trabecular thinning of osteomyelitis, are but three examples of the potential usefulness of this new weapon.

The diagnostic possibilities opened up by this tube are such that it is imperative to consider the economic situation involved. The increasing distribution throughout lay and professional fields of small x-ray units, by high pressure manufacturers, has resulted in much routine work being "taken away" from the radiologist's domain; it was by this very routine work that his main overhead was defrayed. The investment involved in the installation of rotating anode tube equipment is approximately as follows: high milliamperage transformer unit, impulse timer, rotating anode tube with tube support and rail, $6,000; vertical high-speed Bucky, mounted, $700; a total investment of $6,700. The tube itself is a minor cost; it is the equipment to operate it efficiently and make proper use of it that is expensive. It is to be hoped that dissemination of small units will decrease in order that patients may have a better chance of having their x-ray examinations conducted under proper circumstances. Only by reasonable concentration of x-ray work in properly equipped medical specialists' hands can such circumstances exist. Doctor Powers is to be congratulated on his distinction of having been the first radiologist in the Bay district to install a double-focus rotating anode x-ray tube.

RECONSTRUCTION OF THE ENLARGED BREAST*

By H. O. Bames, M.D.
Los Angeles

Discussion *by John Hunt Shephard, M. D., San Jose; Nelson J. Howard, M. D., San Francisco; Arthur E. Smith, M. D., Los Angeles.*

IN two papers, published last year, I presented a review of general considerations involved in plastic operations of the breast; technique was stated only in general terms.[1, 2]

Today I submit in film and words the operative technique, as well as preoperative preparation and postoperative results.

For the purpose of this paper, we consider as enlarged any breast which is larger than its owner desires, regardless of whether relief is requested on the basis of physical symptoms or mental distress

* Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

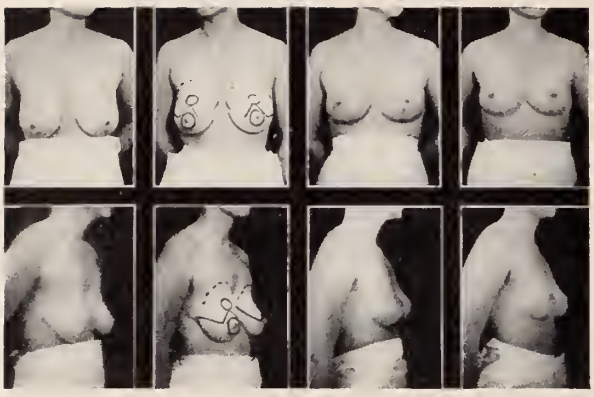


Fig. 1.—Front and three-quarter profile, showing condition and progress in various stages.

Column 1 shows symmetrical hypertrophy of both breasts, about one-third larger than would be normal for the size of her body; degree of ptosis is three inches below anatomical lower border.

Column 2 shows preoperative marking of incision lines, denoting new locus of nipple; circumcision line of areola; anterior line of new lower border with inverted "V"; posterior lower border is not visible, but parallels the new anterior border and coincides with the normal anatomical lower border of the breast. The dotted line denotes the upper limit of the area to be undermined for the new bed of the gland.

Column 3 shows the reconstructed breast three weeks after operation, reduced in size, secured in normal position. All incision lines and suture marks obviously noticeable.

Column 4, result a year later shows normal size, position, and esthetic contour well maintained.

over the abnormal development; regardless also of whether the enlargement and ptosis is only relative, or whether it amounts to actual gross deformity, for the technique of correction is essentially the same.

We assume also that a careful examination has proved the breast mass free of all pathology, except fatty infiltration or benign glandular hypertrophy.

Let us, therefore, proceed with the running of the film.

INSPECTION

We note that both breasts are about one-fourth larger than seems normal for this body, and that there is a ptosis of fully three inches. We note also that the areola has enlarged to twice the average size.

DELINEATION

Determining the new locus of the nipple is more by sculptural visualization than by actual measurements, with reference to certain anatomical landmarks. With the patient in the upright posture, we mark, with brilliant green, a circle 1½ inches in diameter, denoting the new locus. Next, the new size of the areola is marked, and while we make it smaller than its present size, we leave it actually larger than the above circle to allow for shrinkage from its overstretched condition. Experience has shown that a nipple formerly devoid of sensation and reaction can thus regain its normal irritability.

A third line is made along the normal inframammary groove, and a fourth one paralleling this third line upon the anterior surface of the breast, these two lines becoming confluent at their mesial and lateral termination.

The fifth delineation marks an inverted "V" from the new nipple locus to the lower border, sufficiently wide to take out the lateral redundancy of skin.

OPERATION

Skin incisions follow exactly these delineations. The gland is freed of all its overlying skin, excepting the nipple and areola, the attachment of which to its blood and nerve supply is most carefully guarded. In furtherance of this object, the periareolar skin ablation is made very superficial. The new bed for the gland is prepared by blunt dissection with the hot gauze sponge.

Proceeding next to reduce the size of the gland, we remove a sector representing approximately one-fourth of the mass, endeavoring to make the section between acini rather than across them, palpation acting as guide. The section is usually taken from the inferolateral area, as we thereby gain a better esthetic form. By closing this defect with a few interrupted sutures, we restore peripheral continuity and recreate the normal conical contour of the gland.

Had the enlargement been due to fatty infiltration instead of glandular hypertrophy, we would have ablated the periglandular fat and left the gland itself undisturbed.

We next close the "V" incision and thereby create a covering flap of skin which admirably fits upon the conical contour.

The gland is now transposed upward in its new bed, the nipple and areola emerging in the new locus and secured there with a row of interrupted sutures.

The fascia of the lower border is coapted with interrupted, nonabsorbable sutures, and the skin wound closed with a running lock suture.

A rubber drain is placed through this wound into the new bed, and left in place twenty-four to forty-eight hours.

Normal location of the gland is obtained by accurate planning of the new bed and its conical covering, rather than by suturing to the fascia. Experience has proved this to be an even better guard against recurring ptosis than fixation to the pectoral fascia.

EVALUATION OF RESULTS

In submitting this technique for discussion, may we suggest that it be checked by the results obtained, as shown in the closing scene of the film, which shows the patient four months after operation.

On the serial photograph, the first line represents front and profile of the condition complained of. Second line: with preoperative delineation of incision lines. Third line: four weeks postoperative. Fourth line: twelve months postoperative.

SUMMARY

The actual technique of reconstructing the enlarged and ptosed breast is submitted in word and Kodachrome film.

Sculptural visualization, more than anything else, is relied upon to secure good esthetic form and firm anatomical fixation.

Nipple, areola, and remaining gland tissue are transferred to their new locus, with blood and nerve supply practically unimpaired, making the reconstruction a true one in form as well as nervous sensibility. Lactation, in so far as this function existed residually in the breast before the operation, is practically uninfluenced by the operation.

Scars are held to a minimum of noticeability by suitable planning of the incision lines, and by placing all tension of approximation on the fascia instead of the skin.

REFERENCES

1. Plastic Reconstruction of the Anomalous Breast (Bames), Revue de Chirurgie Structive No. 2, June, 1936.
2. A Review of Plastic Operations on the Breast (Bames), Medical Record, April, 1936.

727 West Seventh Street.

DISCUSSION

John Hunt Shephard, M.D. (Medico-Dental Building, San Jose).—While enlarged breasts do not endanger life, they frequently do cause both physical and mental discomfort, entitling the patient to our earnest and sincere consideration.

For years these unfortunate individuals have had to choose between accepting the *status quo* or submitting to a mammectomy. Today we can offer them relief from their discomfort without partially desexing them, which, at times, does bring about serious psychological and domestic discord. Doctor Bames, by word and film, has shown us what he has been able to do for these patients, and he is to be congratulated upon his results.

My personal experiences with plastic operations on the breast is very limited; and while my results have not been as beautiful as Doctor Bames', my patients have been most grateful.

One point which Doctor Bames mentions in the technique of this operation I want to emphasize, namely, the preservation of the nerve and blood supply to the nipple and areola. The major blood supply to this area is quite superficial, and in the reflection of the superior flap one must keep his dissection close to the skin and do the most of it by a moist sponge over the fingers, instead of using a scalpel or scissors.

While the technique of this operation is not difficult, those of us who do not possess the eye of the sculptor will not be found exhibiting our results.



Nelson J. Howard, M.D. (350 Post Street, San Francisco).—Count as fortunate those physicians who saw the colored motion pictures shown by Doctor Bames at the 1937 State meeting. No written description could convey half so well the operative technique or the cosmetic after-results as presented in this film.

It seems an unnecessary comment that only pathologically normal, distinctly enlarged or exceedingly pendulous breasts should be submitted to these operative procedures. Where one should draw the line between abnormally enlarged, or exceedingly pendulous breasts and normal pectoral protuberances, is the difficult thing to determine. In the minor grades of these abnormalities, especially in the distinctly pendulous breast, one can be surprised at the return of contours and more pleasing form which follow the prolonged wearing of modern types of uplift brassiers. This change is an anatomical one, the so-called suspensory ligaments of the breast shorten, and the subcutaneous fat of the upper border of the breast is no longer atrophic or gravitated dependent. With painful breasts, in which pain fails to be relieved by adequate support, one cannot expect pain to disappear by this operation. The sole purpose, then, of the operation is the cosmetic effect, which, however, can be obtained by effective modern brassiers, unless the hypertrophy of gland or fat tissue is extreme.

Any operative plastic procedure on the breast must preserve the nipple and areolar intact for physiological as well as psychological reasons. I should like to know whether Doctor Bames has encountered sloughing and necrosis of these structures in this operation. Again, it would be of interest to know how many of these patients have had subsequent pregnancies, and how many of them were able to nurse their babies.



Arthur E. Smith, M.D. (1930 Wilshire Boulevard, Los Angeles).—Plastic reconstruction of the enlarged breast has been done for many years with a varied degree of success by plastic surgeons in Europe. Inefficient surgical planning and procedure often resulted in the loss of nipples, asymmetry of the breasts, and excessive scarring and interference with normal glandular function. Therefore, plastic surgeons in the United States were reticent in accepting the surgical results of their European colleagues. One of the first reconstructive plastic procedures for mastopexy was suggested by Dartiques, who adjusted the breast tissue by axillary resection. Then, later, the perpendicular subareolar incision with the excision of superfluous glandular tissue was practiced which resulted in large disfiguring scars and asymmetry of breasts. Thorek, in 1922, described his surgical procedure, which was a great step forward in plastic reduction and consisted of making a supra-areolar curved incision over the pendulous mass, and a second curved incision just beneath the breast. Excessive adipose and glandular tissues between the two incisions were removed. The nipple and areolar tissues were separated from the surrounding skin by a circular incision. The surrounding skin was undermined and the reduced breast was pushed upward beneath the loosened skin. The nipple and areolar tissue emerged through a new opening at the desired location. By this technique the curved scar line was located beneath the breast.

For a number of years I have employed a two-stage technique in the plastic reconstruction of the enlarged breast. The primary stage is for the establishment of collateral circulation and consists of loosening the skin over the major portion of the breast. This diminishes the possibility of losing the nipple or skin by superficial necrosis at the time of the major reconstruction.

Two months later the second operation is done. One-half inch of skin outside the areolar tissue margin is included within the circular incision. The skin is de-epithelized to the skin-areolar tissue junction. Two convex incisions are made: the upper one over the breast, and the lower one in the curved outline beneath the breast. No vertical incisions are made. A disk of skin, the diameter of the areolar tissue only, is removed at normal breast level and nipple location. The skin over the entire breast is loosened and the circumference of the breast reduced; the newly molded breast is pushed upward, and the nipple and areolar tissues are advanced through the circular opening. The one-half inch of de-epithelized skin surrounding the areolar tissue is covered by the surrounding skin which gives greater skin surface contact and better blood supply. The only scar line is situated beneath and hidden by the overhanging breast.

I wish to emphasize that the greatest surgical exactitude is necessary in plastic reconstruction of pendulous, hypertrophied breasts in order to create proper contour, preserve glandular function, prevent surface necrosis and scarring, lumping, and asymmetry. Women in the social, theatrical, and business world, who possess excessively large breasts are subjected to a physical and psychic handicap, which can be overcome by proper surgical procedures.

SIMMONDS' DISEASE (HYPOPHYSEAL CACHEXIA)*

CLINICAL REPORT OF SEVERAL CASES WITH DISCUSSION OF DIAGNOSIS AND TREATMENT

By Roberto F. Escamilla, M.D.
and
Hans Lisser, M.D.
San Francisco

Discussion *by C. Kelly Canelo, M. D., San Jose; Lewis T. Bullock, M. D., Los Angeles.*

IN 1914, Simmonds,[1] a pathologist of Hamburg, first suggested that the symptom-complex, now recognized as hypophyseal cachexia, was due primarily to diminished function of the anterior hypophysis. He arrived at this conclusion after

* From the Department of Medicine, University of California Medical School, San Francisco.
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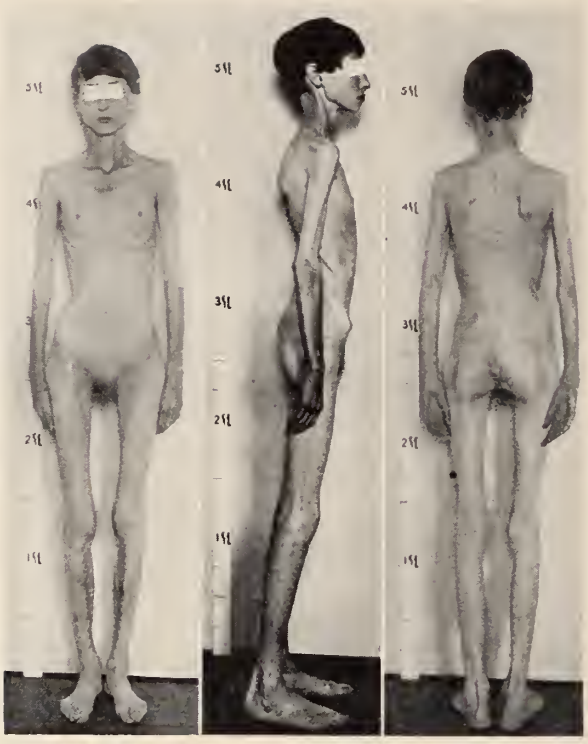


Fig. 1

several years of study of the structural changes in the pituitary gland in correlation with the clinical findings. As a result, the condition now known as Simmonds' disease has come to be generally recognized as a clinical entity.

Chief and most constant characteristics of the syndrome are: (1) marked loss of weight, frequently progressing to emaciation; (2) diminished sexual function; and (3) a very low basal metabolic rate. Other characteristic but less constant findings are: asthenia; intolerance to cold; premature senility; psychic changes; gastro-intestinal upsets; dry skin and hair, with loss of the latter particularly in the axillary and pubic regions; atrophy of the jaw-bone, and dental caries; low blood pressure; slow pulse rate; flat glucose tolerance curve with tendency to hypoglycemia (occasionally a diabetic type of curve); diminished specific dynamic reaction to food; secondary anemia; and visceromicria. The disease may occur in either sex at any age, but is most frequently found in females during those age periods when pituitary integrity is in greatest demand, as at puberty, during the menopause, or after many pregnancies.

Altogether, about 154 typical cases had been reported prior to 1936. However, as recently as 1933, Silver [2] accepted for his survey as cases of true Simmonds' disease only those in which necropsy findings had been reported—a total of forty-one cases at that time. The clinical picture now seems to be fairly well established, and is not likely to be confused with any other, with the possible exception of a state of severe malnutrition due to anorexia nervosa, of which amenorrhea may be a consequence.

We wish to present case histories of eight patients whose clinical findings, in our opinion, necessitate a diagnosis of Simmonds' disease, and one patient who was originally so classified but whose eventual course caused us to favor a diagnosis of anorexia nervosa. The fact that this number of cases has been collected in one clinic within a few years seems to indicate that the malady is not as rare as has been heretofore supposed. It is hoped that this presentation will stimulate consideration of the diagnosis of Simmonds' disease if cachexia is encountered that cannot be explained by any of the common causes.

REPORT OF CASES*

Case 1 (Fig. 1)—C. M. (43169M), a 25-year-old, single, Irish, female office worker, was admitted to the University of California Hospital on March 17, 1928, complaining of loss of weight and amenorrhea. In the past she had had the usual childhood diseases. It is of interest that one brother was thin. She had never menstruated.

When the patient was fifteen years of age she weighed 90 pounds (41 kilograms). At that time she had an attack of influenza, following which she began to lose weight rapidly and had associated symptoms of anorexia with slight constipation, and vomiting. A gastro-enterostomy was performed, resulting in some relief from vomiting. However, she continued to lose weight gradually, although she had occasionally slight temporary increase in weight during periods of rest and greater intake of food. Administration of ovarian and pituitary tablets did not improve her condition.

Physical Examination.—The patient's height was 62¾ inches (159 centimeters); her weight, 59¾ pounds (27 kilograms)—ideal weight, 124 pounds (56.3 kilograms). The pulse rate was 68 to 78 beats per minute, and the temperature was 36 to 37 degrees centigrade. She was emaciated. A downy growth of hair was present on the cheeks and upper lip, but elsewhere the hair was sparse and felt dry, especially in the axillary and pubic regions and outer thirds of the eyebrows. The jaw-bone was atrophied, but the teeth were in fair condition. The breasts were atrophic. Blood pressure was 88 millimeters of mercury systolic, and 64 diastolic. The finger nails were soft and ridged, and the tips of the fingers were cyanotic. Pelvic examination by Dr. Frank Lynch showed a small midline thickening which may have been a vestigeal uterus; and endoscopic examination revealed complete absence of the cervix.

Laboratory Findings.—Blood: hemoglobin, 78 per cent (12.2 grams) (Sahli); red blood cells 4,800,000 per cubic millimeter; white blood cells 9,000 per cubic millimeter, with a normal differential count, including 2 per cent eosinophils. Urine: faintest possible trace of albumin on one examination. Basal metabolic rate, 18.5 per cent minus. Blood sugar (fasting), 89 milligrams per cent. Roentgenological examination showed the sella turcica to be small and shallow; the bone age was that of an adult. Aschheim-Zondek and Allen Doisy folliculin tests on the urine, made in the laboratory of Dr. Herbert M. Evans, were negative. The blood was examined for anterior pituitary sex factors by Dr. C. Frederic Fluhmann of the Stanford Medical School, and these were not found.

Course and Treatment.—The patient was given anterior pituitary substance (Armour) in doses of five grains three times daily, with pancreatin. She improved slightly, but gained only 1¼ pounds in four months, at the end of which time the basal metabolic rate was 10.1 per cent minus. Eight months later she was found to have a diabetic type of glucose tolerance curve (blood sugar: fasting, 172; thirty-minute specimen lost; one hour 336; two hours 178 milligrams per cent; there were large amounts of sugar in the urine). One month later the curve had leveled somewhat as follows: fasting, 80; one-half hour 163; one hour 240; two hours 97 milligrams per cent. The patient was started on insulin therapy and a weighed diet of 1,620 calories. At this time her weight was 61 pounds (27.8 kilograms), and it gradually increased over a period of 10 months to 70 pounds (31.8 kilograms). The basal metabolic rate rose to 7.5 per

* Case histories of nine patients were given when the paper was read. Only three are printed in California and Western Medicine; others will appear in the reprints.

cent plus. Because she began to have insulin reactions and some gastric symptoms, medication was stopped for a time, but was later resumed in limited doses. At this time the glucose tolerance curve was flat (blood sugar: fasting, 81; one-half hour 129; one hour 84; two hours 77 milligrams per cent). The following year, despite continued treatment with insulin, anterior pituitary substance, ovarian extract, and thyroid extract, the patient began to fail in health and to lose weight. Fourteen months later (February, 1931), her basal metabolic rate had dropped to 37.3 per cent minus, and her weight had decreased to 61¾ pounds (28 kilograms). Injections of theelin were given, but the downhill progress continued. She was seen last at the University of California clinic on September 10, 1931, her weight at that time being 59¼ pounds (26.8 kilograms). Dr. Richard E. Graun of Los Gatos later informed us that she had died in August, 1933. During the last two years of life her course had continued downhill, despite general supportive measures. When seen on the day of her death, she was comatose and very emaciated, and weighed "not more than 50 pounds" (22.7 kilograms); her pulse rate was 44, and the blood pressure was 58 millimeters of mercury systolic, with no definite diastolic level. Permission for an autopsy, unfortunately, was refused.

* * *

Case 2.*—L. B. (73089M), a 17-year-old, American schoolgirl was admitted to the University of California Hospital on September 11, 1933, with complaints of loss of weight, amenorrhea, and increased growth of hair.

One brother and a cousin were Mongolian idiots. In the past the patient had had only measles. Menarche had occurred at the age of eleven years, and her menstrual periods were regular until the beginning of her present illness. At the time of onset of symptoms her weight was 127 pounds (57.7 kilograms).

Six years before admission to the hospital the patient had had a severe febrile illness, accompanied by an extraocular paresis. During the three weeks of illness she lost 25 pounds (11.3 kilograms) in weight. She then developed anorexia and constipation, and continued to lose weight. Amenorrhea had been present from that time. Four years before entry a downy growth of hair appeared on the face, neck, and back. Two years later she had attacks of acute lower abdominal pain, for which appendectomy was performed without relief resulting. For six months prior to entry she had noted intolerance to cold, slight asthenia, and occasional edema of the ankles in the evening. Basal metabolic rates determined six months before entry were minus 32 per cent and minus 29 per cent. Treatment with various drugs, including thyroid substance, ovarian extract, theelin, and insulin, was of no benefit. Her total loss of weight was 53 pounds (24.0 kilograms).

Physical Examination.—The patient's height was 67¾ inches (172 centimeters); her weight, 74 pounds (33.6 kilograms)—ideal weight, 137 pounds (62.3 kilograms). The pulse rate was 40 per minute, and the temperature 34 degrees centigrade. She appeared cachectic, and her skin was dry. A growth of downy hair was visible on the face, back, and extremities. The pubic hair showed normal distribution. The heart was small. The blood pressure was 90 millimeters of mercury systolic; 70 diastolic. A pelvic examination performed by Dr. Charles Hayden showed the uterus to be small, and the external genitalia infantile. The extremities were cold and cyanotic, and there was slight edema of the ankles.

Laboratory Examinations.—Blood: hemoglobin, 78 per cent (10.8 grams) (Sahli); red blood cells 3,900,000 per cubic millimeter; white blood cells 9,100 per cubic millimeter, with a normal differential count including one per cent eosinophils. Basal metabolic rate: 47 per cent minus. Glucose tolerance test: blood sugar (fasting), 76; one-half hour 66; one hour 90; two hours 74 milligrams per cent. Whole blood cholesterol, 149 milligrams per cent. Serum calcium, 11.9 milligrams per cent; phosphorus, 3.1 milligrams per cent. Plasma chlorids, 529 milligrams per cent. In the electrocardiogram the complexes were small in all leads. In the roentgenological examination the sella turcica was seen to be normal. Pyelograms showed the kidneys to be normal in size and shape. The bone age was over eighteen years. No abnormalities were observed in the chest, except for a small heart.

Course and Treatment.—The progressive loss of weight continued, despite a daily intake of 1,200 to 2,300 calories. Administration of thyroid extract for ten days, followed by injections of Antuitrin S for eleven days, did not improve the patient's condition. During the fourth week she suddenly became very weak and the edema of the ankles increased. The visual fields, which had been normal, showed marked concentric contraction. She finally lapsed into coma and died, despite the use of stimulants, fluids injected intravenously, and large amounts of adrenal-cortical extract (Eschatin) on the day of her death. The last weight determined was 62 pounds (28.2 kilograms).

Postmortem examination showed the presence of a chromophobe hyperplasia of the anterior pituitary, atrophy of the adrenal cortex, immature ovaries, and some terminal bronchopneumonia. The viscera were small.

* * *

Case 3.—P. P. (U 12003), a 17-year-old, white American schoolgirl, was admitted to the University of California Hospital (service of Dr. Francis Scott Smyth and Dr. Howard Naffziger) on April 1, 1937. Her complaints were loss of weight, amenorrhea, and easy fatiguability.

One cousin had died of tuberculosis, and a maternal grandmother of carcinoma. The patient had had the usual childhood diseases. Menarche had occurred at the age of twelve, and her periods had been fairly regular and normal until onset of her present illness. Her average weight had been 125 to 130 pounds (56.8 to 59.0 kilograms) during the year before her illness began.

Ten months before entry into the hospital the patient had had some anorexia, and had begun to lose weight. After a two-month interval, she had a normal menstrual period; and then complete amenorrhea. She was troubled also by sensitivity to cold, constipation, and some irritability and easy weeping. Six months before entry, a basal metabolic rate was found to be minus 40 per cent; and the administration of thyroid substance was started which the patient was still taking at the time of entry. The metabolic rate increased to as high as 5 per cent plus, but she felt no better and continued to lose weight. Her weight at onset of illness had been 130 pounds (59.0 kilograms); and she lost a total of 40 pounds (18.2 kilograms). She had some loss of axillary and pubic hair. Asthenia developed gradually, and finally she had to stop school.

Physical Examination.—The patient's height was 64½ inches (164 centimeters); her weight, 89.7 pounds (40.8 kilograms)—ideal weight, 125 pounds (56.8 kilograms). Her pulse rate was 56 per minute, her temperature 36.4 degrees centigrade. She was very thin; her movements and speech were rather slow. The skin was dry, with slight pigmentation over the abdomen (probably due to ultraviolet light treatments). The hair was normal in texture, scant in the axillae, and slightly thinned in the pubic region. The teeth were in good condition. The breasts were fairly well developed. The heart was small. Blood pressure was 94 millimeters of mercury systolic and 60 diastolic; it decreased to 74 millimeters of mercury systolic and 58 diastolic, when she was raised from a prone to a standing position (postural hypotension—Schellong-Strisower reaction). The viscera were small. Pelvic examination by Dr. Alice Maxwell showed that the uterus was normal in size, and the left ovary cystic. The extremities were cold.

Laboratory Examinations.—Blood: hemoglobin, 92 per cent (13.2 grams) (Sahli); red blood cells 4,700,000 per cubic millimeter; white blood cells 6,800 per cubic millimeter, with normal differential count, including 2 per cent eosinophils. Basal metabolic rate: 24 per cent minus (the patient still taking thyroid). Glucose tolerance test (1.75 gram per kilogram): fasting, 53.8; one-half hour 108.5; one hour 127.8; two hours 97; three hours 71.6; four hours 60; five hours 105.2; six hours 100.1 milligrams per cent. Nonprotein nitrogen: 42.2 milligrams per cent. Blood urea nitrogen, 22.8 milligrams per cent. Creatinin, 1.8 milligrams per cent. Whole blood chlorids, 351 milligrams per cent (as NaCl). Plasma chlorids (later), 544 milligrams per cent (as NaCl). Serum calcium, 9.8 milligrams per cent. Phosphorus, 6.68 milligrams per cent. Visual fields normal. Gastric analysis (fasting specimen only), no free HCl; total acidity not over two units. Tuberculin tests, negative. Roentgenological examination showed the sella

* This case, with discussion of pathologic findings, will be reported more fully in a later paper.

turcica to be normal; the bone age was seventeen to eighteen years; the lungs were clear; the heart small.

Course and Treatment.—The patient was started on daily injections of whole pituitary extract (Armour), but these did not have any appreciable effect. She was then started on Polyansyn, and discharged from the hospital. However, the regimen was not well followed at home, and she was finally readmitted with the general condition definitely worse. She was then started on a regimen of Polyansyn and insulin together, but after two weeks of this she became disoriented and depressed and refused to eat. The therapy was stopped and psychotherapy begun, under which she gradually cleared and began to take food satisfactorily. This resulted in a gain in weight of 25 pounds (11.4 kilograms) in seven weeks, and on discharge the patient weighed 104.7 pounds (47.6 kilograms). Her response to psychotherapy and increased intake of food would suggest that the primary diagnosis here should have been anorexia nervosa, rather than Simmonds' disease. This case is an excellent example of the occasional difficulty experienced in differentiating these two conditions clinically.

DIAGNOSIS

All of the patients whose histories are given above manifested the cardinal findings of Simmonds' disease as noted in the introductory paragraphs of this paper. Each had had considerable loss of weight, the least being 22.5 pounds (10.2 kilograms) (Case 7) and the most, 53 pounds (24.0 kilograms) (Case 2); the average loss of weight was 35.6 pounds (16.1 kilograms). At least five patients (Cases 1, 2, 3, 4, and 5) showed definite emaciation, being, respectively, 64¼ pounds (29.2 kilograms), 63 pounds (28.7 kilograms), 35 pounds (15.9 kilograms), 43 pounds (19.5 kilograms), and 51 pounds (23.2 kilograms) under their ideal weights. One of the female patients in whom the onset had occurred at puberty had never menstruated; while amenorrhea lasting from ten months to seventeen years was experienced by each of the others. The basal metabolic rates of all the patients were low, varying from minus 18 per cent to minus 47 per cent and averaging 32.1 per cent minus.

Concerning the less constant characteristics: All but one of the patients were females. Onset of illness occurred at or shortly after puberty in three patients; early in the second decade of life in four; in the third decade in one; and at the beginning of the fourth decade in one (the male patient, Case 7). The latest onset among the female patients (Case 6) followed a fifth pregnancy which had been attended by severe complications. At the time of examination the duration of the disease had been from ten months to seventeen years. All of the patients complained of asthenia, and three specifically of loss of libido although this symptom was not always ascertained in the unmarried patients. Seven patients had noted intolerance to cold. In regard to psychic changes, four patients had experienced decided slowing of mental processes (Cases 4, 5, 6, and 7); three had had a feeling of depression (Cases 3, 5, and 9); and one (Case 6) had at one time been apathetic to the extent of suggesting a diagnosis of "dementia praecox." Gastro-intestinal symptoms were of common occurrence, and were specific complaints of seven of the patients. Slight transient diabetes insipidus was present in one instance (Case 9). Anorexia, which was a frequent symptom, undoubtedly contributed to the continued loss of weight, but was not considered to be the primary cause. However, it is of interest to note that the subsequent course of Case 3, with a continued gain in weight under psychotherapy and increased intake of food, caused us to doubt the diagnosis and eventually classify the patient as a case of anorexia nervosa.

Of the physical findings, dry skin was noted in eight of the patients, but scanty axillary and pubic hair was noted in only three. Four patients had dental caries, and all had hypotension (the limits were 80 to 100 millimeters of mercury systolic and 50 to 70 diastolic). In the female patients the internal genitalia were small in six instances, and in one patient (Case 1) the cervix was absent. The one male patient showed slight genital atrophy.

The laboratory findings were of some interest. In the glucose tolerance studies, definitely flat curves were found at some time in seven patients, while two (Cases 1 and 5) had curves of the diabetic type; however, one of the latter was transient. In Cases 7 and 9 there were definite symptoms of hypoglycemia. Three patients were tested for specific dynamic reaction to food, which was found to be diminished in two. A mild secondary anemia was present in three cases, and a slight eosinophilia in one. The blood cholesterol was normal in four cases, and elevated in two. In sevent patients the sella turcica was normal, and it was small and shallow in one (Case 1, onset aet. 15).

Therefore, in our series, loss of weight, amenorrhea in females and loss of libido in the male patient, and lowered basal metabolic rates, were constant findings; the other characteristics were more or less variable.

TREATMENT

Since it is accepted that the pathologic physiology of Simmonds' disease is related to failure of the anterior pituitary, the logical treatment would seem to be therapy by replacement with anterior pituitary extract. For some of our recent cases an extract prepared by Professor J. B. Collip of Montreal (polyansyn) and kindly furnished to us by Ayerst, McKenna and Harrison, has been used. Administration of this extract caused some subjective improvement in general well-being, and appetite, and decrease of mental sluggishness; but except in one patient (Case 6), it did not result in a marked gain of weight. The symptoms of amenorrhea and lack of libido were not affected. Insulin therapy improved the condition of one patient (Case 1) temporarily, and caused a definite gain in two others (Cases 5 and 7). However, it must be administered with caution in this disease because of the frequent tendency to hypoglycemia. It is interesting to note that in Case 5, Polyansyn was necessary in addition to the insulin in order to cause continued gain in weight. Thyroid medication gave temporary benefit to one patient (Case 6) early in the course of the disease, but later was poorly tolerated. Five other patients who were treated with thyroid substance reacted unfavorably. This form of therapy seemed to hasten loss of weight, and to cause increased nervousness. Daily injections of Follutein gave temporary benefit to one patient early in the disease.

It is felt that preparations of anterior pituitary should be tried in adequate amounts and for long periods of time. Further observation of our patients is considered necessary before we can definitely accept the preparations available at present as being specifically beneficial.

SUMMARY

Nine cases are presented in which the history and findings were suggestive of Simmonds' disease. The classical and most constant findings are loss of weight, loss of sexual function, and lowered basal metabolic rate. The authors feel that this disease should be considered when a patient presents continued loss of weight for which no other cause can be found. Clinical differentiation from anorexia nervosa is occasionally very difficult, and the subsequent course of one of our cases caused it to be placed in this category.

Treatment is discussed; and, although therapy by replacement with anterior pituitary extract seems logical, its administration has thus far, at least in our experience, been somewhat disappointing. More potent preparations are needed. Despite the low basal metabolic rates found in these patients, administration of thyroid substance is ineffectual. A fattening regimen, with the use of insulin, may be tried cautiously.

The condition of some patients may improve spontaneously, but the eventual prognosis is usually grave.

384 Post Street.

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DISCUSSION

C. Kelly Canelo, M.D. (Medico-Dental Building, San Jose).—Simmonds' disease is a condition of extreme debility and cachexia, caused by lack of function of the anterior lobe of the pituitary.

The most common etiological factor is an obstruction to the blood supply resulting from an embolus. Tumors, cysts and inflammatory processes of the pituitary itself are frequent. It is not uncommon to find a history of frequent pregnancies and then a delivery complicated by hemorrhage and infection. Howard reports a case of Simmond's disease, proved at autopsy, in a woman of twenty-three years, due to a tumor of Rathke's pouch, producing pressure on the pituitary.

The cardinal symptoms of this disease are: (1) Loss of weight and strength; (2) Loss of sex function; (3) Low basal metabolic rate. Weight loss is often as much as 65 per cent of the original weight of the patient. Brattan reported a case in a woman who died nine months after a long series of pregnancies; autopsy showed all the usual findings of Simmond's disease, except that there was no weight loss.

Loss of sex function includes amenorrhea and loss of libido and potentia.

The basal metabolic rate is frequently from 30 to 40 per cent below the calculated normal rate.

Other findings usually present are: dry, pallid skin, falling of the hair and teeth, senile atrophy of the lower jaw, decalcification of the bones, hypotension, subnormal temperature, bradycardia, splanchnomicria, low-fasting blood sugar and loss of specific dynamic reaction to protein, carbohydrate, and fat.

In making a diagnosis of Simmonds' disease, one must not be caught in the "endocrine whirl," but must rule out all other debilitating diseases. Anorexia nervosa mimics Simmond's disease and requires competent psychiatric observation to rule out this possibility. In the absence of pituitary signs, cancer must be thought of and diligently searched for. Addison's disease most usually shows pigmentation especially of the mucous membranes, and in this condition wasting is not the usual finding.

In spite of basal metabolic rates of minus 30 to 40 per cent, thyroid extract does not benefit these patients even though their metabolic rate be brought up to normal by means of thyroid.

This series of cases, although carefully controlled and treated with a reliable anterior pituitary preparation, has failed to show the complete response that might be desired.

Turner, however, reports a case of Simmonds' disease which responded quite promptly and completely with a similar anterior pituitary preparation.

Hawkinson, in 1935, reported one case that responded satisfactorily to A. P. L.

Herman reported, in the German literature in 1934, the good results he obtained in three cases by the use of prolan.

Barr reports one case that showed marked improvement with storage of calcium, phosphorus and nitrogen on no specific treatment, but adequate and attractive diet, rest, and good nursing care; it is possible that this was a case of transient Simmonds' disease due to mere suppression of the anterior lobe of the pituitary, or it may have been a case of anorexia nervosa.

Kylin reports a series of twenty-three cases treated by implantation of calves' hypophyses. Of these patients, three had been under observation only a short time at the time of his report; of the other twenty, eighteen showed good results.

Steinitz, in 1932, gave a report of six cases. He treated his cases at first with pituitary preparations alone and found that he was able to correct the trophic changes, but the weight loss either progressed or remained unimproved. In spite of low-fasting blood sugars, he found that the glucose tolerance curves suggested a lack of insulin; accordingly, he added insulin to his treatment and achieved a satisfactory response in his patients.

In the majority of patients this latter method of treatment would seem to be the most satisfactory at the present time.

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Lewis T. Bullock, M.D. (1136 West Sixth Street, Los Angeles).—There are many problems concerning Simmonds' disease that remain unanswered. In theory, at least, it is due to a lack of all of the secretions of the anterior pituitary gland. It is safe to say that we will not entirely understand this syndrome until we know all of the essential aspects of the physiology of the pituitary, and that day is still for the future. A case of pituitary cachexia, however, provides the inquisitive physician with a remarkable opportunity to study in man the disturbances produced by the absence of pituitary secretions, and it may be that important physiological data will be developed from this source.

The essential problem of why these patients lose weight and die is not entirely clear. Though necessary for normal growth in stature, it has not been proved that the lack of growth hormone is alone responsible for the loss of weight. Even if this were true the mechanism is not understood. Is it a lack of appetite and food intake, a lack of absorption, or a lack of utilization of absorbed food elements? I had the pleasure of observing one of the autopsied patients in this series, who lost weight in spite of an increased and adequate consumption of food. The flat glucose tolerance curve and absence of specific dynamic action of protein raise the question of inadequate absorption. If it is from a lack of utilization of absorbed material, the metabolic changes responsible for this require clarification. The lack of thyrotropic hormone would not explain the loss of weight or death and deleterious results which have followed its administration. It does not seem probable that the gonadotropic hormones are important in maintaining weight, and life and improvement reported in the literature from the use of these substances seem questionable. Hypoglycemia is often present, but there is no proof that this is the usual cause of death. Adrenal insufficiency is a possible cause of the terminal coma and death, but this has not been confirmed by experience. In the absence of more detailed knowledge concerning the mechanism of the loss of weight and the cause of death, it is obvious that treatment must be unsatisfactory.

The clinical aspects of this syndrome have been well reviewed, and the characteristic picture should be in the diagnostic armamentarium of every physician. I should

like to add the loss of pubic hair to the list of cardinal findings. This change was present in thirty-five of Silver's forty-one autopsied and proved cases. Doctors Escamilla and Lisser have wisely emphasized that the other findings of cachexia, amenorrhea, and low basal metabolism can be exactly duplicated by anorexia nervosa. I have seen a similar case of a patient completely cured by psychotherapy alone. This important finding which distinguishes Simmonds' disease from anorexia nervosa is absent in almost all of the cases reported in the literature as having been cured by various injections or transplants. No claim for cure can be accepted as conclusive when this is absent. The characteristic remissions with a prolonged course of the disease, up to forty-four years in proved cases, must also be considered in relation to therapeutic triumphs.

I wish to congratulate Doctors Escamilla and Lisser on their excellent report of the clinical aspects of this syndrome, and most particularly upon their sound, careful and conservative approach to the problem of therapy. It is by studies of this type, with careful observations of the results obtained from available preparations, that we may finally arrive at a preparation capable of replacing the essential secretions of the anterior pituitary that are lacking in Simmonds' disease.

❦

Doctor Escamilla (Closing).—I wish to thank Doctor Canelo and Doctor Bullock for their discussions, which have contributed substantially to a more complete consideration of Simmonds' disease. Doctor Canelo has added data concerning the types of treatment utilized for this disease. Doctor Bullock has stressed our inability at present to explain adequately some of the characteristics of the disease. He has added the interesting suggestion that loss of pubic hair should be included in the list of cardinal signs. It is true that a recent review of the literature has revealed more or less thinning or loss of axillary and pubic hair in 81 per cent of sixty-nine autopsied cases. This is essentially the sexual hair, and may be related to lack of the gonadotropic fraction from the anterior pituitary. However, it is frequently a late development and is most marked in the far-advanced or very severe cases. It seems safe to state that the clinical diagnosis can frequently be made with reasonable certainty, even if there has been little or no thinning of axillary or pubic hair, and therefore, in our opinion, its inclusion as a cardinal or essential finding does not seem justified. Indeed, the patient which Doctor Bullock observed (Case 2 in the paper), who died and was found to have pituitary pathology, had abundant pubic and axillary hair, yet in every other respect was a most typical example of Simmonds' disease. It is of interest to note that since this paper was presented communications have been received from colleagues in several parts of the state, describing cases which apparently can be classified as Simmonds' disease. This seems a further confirmation of the suggestion that the disease is more common than heretofore suspected.

MONOCYTIC LEUKEMIA: SOME BLOOD AND BONE-MARROW STUDIES*

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Discussion *by Harold P. Hill, M.D., San Francisco; A. M. Moody, M.D., San Francisco; A. G. Foord, M.D., Pasadena.*

CASES of monocytic leukemia, so far studied by the author, have exemplified the necessity of careful identification of both mature and primitive monocytes in the blood. Observations require repeated verification. This is the more true because of the close similarity of the clinical picture to that of other types of acute leukemia.

The sudden, although transient appearance of considerable numbers of myelocytes in the blood during the course of monocytic leukemia, and the occasional finding of noticeable numbers of cells closely like or identical in morphology with mature and primitive monocytes in the blood of cases of acute myeloblastic leukemia suggest a close relationship of these cell types.

TWO TYPES OF BLOOD PICTURE

In general there are two types of blood picture in monocytic leukemia:

1. The one occurs most often in patients whose condition tends to be less acute and who have short periods of slight improvement, suggesting remissions. In these cases the blood picture may show an inclination to become partially myeloblastic and myelocytic as a terminal event. It appears to be due to the occurrence of this type of case that controversy as to the existence of monocytic leukemia as a separate form so long existed. In this type the total white count is either within normal limits or is already moderately elevated when the patient is first seen. The count may show considerable day-to-day variation, but shows a general tendency to rise as the disease progresses. The platelet count also varies, but usually remains definitely subnormal and progresses to a low level, accompanied by a lengthened bleeding time. While the neutrophils are reduced in percentage, the absolute number remains, for the most part, above the lower limit of normal, and rises with the increase in the total leukocyte count. Lymphocytes also usually increase in absolute numbers with the leukocyte increase.

It is important to note that in one patient who was classed within this group, and in which the myelocytic cells reached 19 per cent of 258,000 leukocytes per cubic millimeter, the monocytic cells were still 51 per cent of all the leukocytes. This was observed during the last few days of life. Two days before death, the monocytic cells were 59 per cent of the leukocytes.

2. With the other type of blood picture some patients show a neutrophilic leukopenia when first seen, although there is a simultaneous left nuclear shift. Progression to transient, complete agranulocytosis, with low total leukocyte count, may occur. The red cell count, hemoglobin content of the blood and platelet count, may still remain comparatively undisturbed at the earlier observations, so that the diagnosis rests largely upon recognition of the monocytic picture. This tendency to agranulocytosis is evident not only during leukopenic phases, but persisted in one patient studied at a time when the total leukocyte count was as high as 130,000 per cubic millimeters.

It is further significant that in this second type of blood picture, primitive myeloid cells are absent from the blood throughout the entire course of the disease, or appear in less conspicuous numbers than ordinarily seen in neutrophilic leukocytosis with a similarly pronounced left nuclear shift.

Relative to this second type in which the more acute cases of monocytic leukemia appear to fall, there can be no question of confusion with myeloblastic leukemia.

* Read before the Pathology and Bacteriology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

GENERAL CHARACTERISTICS

In all cases there is early and progressive anemia with red cell counts of one and one-half to two million per cubic millimeter and hemoglobin of 30 to 40 per cent (Sahli) (5.16 to 6.88 grams per cent). In general, the color index may be moderately reduced in the earlier phases to rise well above the normal later. In one case with a red cell count of 1.5 million per cubic millimeter the mean corpuscular volume of the red blood cells was approximately 14 per cent above the normal, and the color index was 7.7 per cent above normal.

Monocytic cells in various stages of maturity make up a noticeably large per cent of the white cells early in the disease. Some are mature monocytes. An increasing number of more primitive cells appear later. In stained blood films the latter show lobulated, furrowed or folded nuclei, with fairly fine chromatin reticulum. In some of these cells the nucleus contains one or two nucleoli. The cytoplasm in the immature cells may be quite irregular in outline, with knob-like or bluntly rounded projections, suggesting motility.

In the cytoplasm immediately surrounding the nucleus, most of the cells have an area filled with very fine lilac-colored granules. This area shows considerable variation in width and extent. The cytoplasm toward the periphery of the cell is basophilic. In some cells the basophilic cytoplasm is reduced to a narrow peripheral rim which is expanded in width to fill the cytoplasmic projections.

In supravital preparations a large proportion of the monocytic cells show the neutral red absorbing vacuoles grouped in the cytoplasm opposite the nuclear indentation in a characteristic "rosette." Some of the cells, presumably less mature forms, contain a minimum of neutral red staining material scattered in what appears to be an unstained rosette. Others contain a somewhat more strongly staining, but still faint rosette.

Some of the cells are small, with narrow rim of basophilic cytoplasm and mottled nucleus. These cells closely resemble lymphocytes. The nucleus is, however, faintly reticular, an occasional nucleolus is found and the cytoplasm is packed with black granules in peroxidase preparations. Many of the larger monocytic cells are quite negative with the peroxidase stain. Others contain but one or two black granules in the cytoplasm with this stain.

Some of the cells are freely motile. Long protoplasmic projections are occasionally formed and these are promptly invaded by mitochondria granules. Occasionally the motile cells show inclusions in the cytoplasm.

The bone marrow is usually hyperplastic and, in the sternum, devoid of fat cells. The stroma is filled with cells. Many of these can be recognized as identical with the monocytic cells seen in the peripheral blood stream. The nucleus is deeply indented, furrowed or roughly lobulated. The nuclear chromatin is finely reticulated and the nucleus may contain one or two nucleoli. The reaction of these cells to the peroxidase stain is variable. In some of them the cytoplasm contains numerous blue-black granules. Some contain but few granules. A few are without peroxidase-staining material in the cytoplasm.

Eosinophils may be numerous. Neutrophilic granulocytes are reduced in number. Small and imperfect foci of erythropoietic cells remain.

Megakaryocytes are rare. Those found contain a condensed and structureless nucleus.

Phagocytic endothelial cells (histiocytes) are sometimes numerous. The cytoplasm of these cells contains vacuoles, pigment granules, and fragments of red cells and leukocytes.

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DISCUSSION

HAROLD P. HILL, M.D. (384 Post Street, San Francisco). Monocytic leukemia is a comparatively infrequent disease. The course is usually subacute. The diagnosis rests entirely on the presence of predominant immature monocytes in the blood.

The clinical picture and course vary little from subacute forms of the myelogenous or lymphatic leukemias. Throat and mouth symptoms may be the first complaint. These lesions in the cases we have seen have been no more severe than in the other forms of leukemia. Anemia with prostration is marked. Thrombocytopenia is present with the usual variable accompaniment of purpura and hemorrhage.

Daily blood studies in three cases showed considerable variation in the total count and percentage of immature monocytes, with no relationship to the patient's symptoms, except a tendency toward an increased count with the progression of the disease.

Adenopathy may be regional or general, but is not as marked as in the lymphatic type. The spleen is enlarged, but does not attain the size of the chronic myelogenous form.

The course tends progressively toward a fatal termination, with but minor remissions in signs and symptoms. No treatment has changed the progressively fatal course. Transfusions improve the patient's symptoms temporarily when the anemia is profound.

❦

A. M. MOODY, M.D. (Saint Francis Hospital, San Francisco).—Doctor Wyckoff's paper deals with certain facts which he has observed in a study of a few cases of monocytic leukemia. These studies add materially to already recorded points for the differentiation of atypical cells present in the blood of leukemic patients.

I believe that the statements in the first two paragraphs are important to all interested in this subject.

The condition is rare, and its course is ordinarily quite rapidly fatal. I have studied only two cases.

There is still a difference of opinion as to the origin of the monocyte, although the majority believe that it arises from reticular tissue.

A recent report by Conway contains experimental evidence of a close relationship between lymphocytes and monocytes.

❦

A. G. FOORD, M.D. (Huntington Memorial Hospital, Pasadena). — Our experiences with cases of monocytic leukemia are quite similar to those of Doctor Wyckoff, and we feel very strongly that there is one type—namely, the second group in Doctor Wyckoff's discussion—which is as clear-cut as cases of myeloid or lymphatic leukemia. Hematologically, the immature cells are typically those of the monocytic series, and at postmortem one finds profound proliferation of the reticulum cells throughout the organs of the body. Smears of the bone marrow and lymph nodes show these cells to be indistinguishable from those in the blood stream. It has always been a mystery to me why these cases were not picked up more frequently in the past. Our experience has been that the clinical pictures have been quite similar to those of the other types of leukemia, and that the diagnosis must be made by careful studies of the blood.

THE LURE OF MEDICAL HISTORY†

HUGH HUGER TOLAND*

A SKILLFUL SURGEON—"TOLAND'S LUCK"

VI

By EDGAR LORRINGTON GILCREEST, M.D.
San Francisco

PART II**

IT has been said of Toland that, "without much originality of conception, he possessed in a marked degree the qualifications we look for in a great surgeon—steadiness of hand and boldness combined with caution." Eminently practical in all that he did, no useless or unnecessary preparations characterized his operations. The rapidity of his execution was remarkable, and was based on his thorough knowledge of anatomy. Few surgeons possessed more manual dexterity. He was cool, imperturbable, and decisive in execution. He had great poise in the midst of an unexpected emergency or eventuality, and "would, when circumstances demanded it, relinquish further procedure without a moments vacillation. As an operator, his success was proverbial: 'Toland's luck,' it was called. But the so-called luck was merited, due to skill."[10]

COURTEOUS TO HIS CRITICS

He is reputed to have operated successfully on innumerable patients who had been refused as hopeless by others. This, in a large part, explains the jealousy of many of Toland's confrères who were free in their criticisms of him. Although aware of this, he was often generous and courteous to his critics. When the welfare of a patient was likely to be sacrificed by the ignorance of his attending physician, however, Toland's manner was somewhat less polished and more direct, and occasionally he would violate all the rules of medical ethics by refusing to protect a brother practitioner who had called him in consultation. The following story in point was given to me by Dr. Herbert Evans as told to him by his uncle, Dr. Robert McLean: "On one such occasion, when his fellow practitioner was late to a consultation and he could wait no longer, hearing from the patient that his physician's diagnosis was an axillary abscess, Toland pinned to the patient's clothes a scrawled note that he who ran might read, 'Dear Doctor ———: Do not lance this patient's auxiliary abscess, or he will bleed at once to death.' It was, of course, an aneurism."

VERSATILITY AS A SURGEON

His operations ran the gamut of general surgery from the head to the toes. As early as 1858 he did trephining, and thyroidectomies, ligated for aneurysms, repaired vesicovaginal fistulae, removed loose cartilages from the knee joint, treated enlarged bursae of the knee joint, did radical bone operations for osteomyelitis and for removal of sequestra, and partial resections of the tongue with ligation of the lingual artery. He also operated on several patients with incarcerated hernia, and on a large double scrotal hernia by invaginating the scrotum on the finger up to the external inguinal ring, and fixing it there with several sutures which were removed when adhesions had formed which prevented the descent of the hernia. In addition, he removed cystic tumors of the breast, treated varicose veins by excision and ligation, and performed iridectomies for glaucoma. It is interesting that Beard of New Orleans and Toland, independently, were the first Americans to perform this operation.

HIS VASCULAR SURGERY

According to his assistant, Robert A. McLean, surgery owes many valuable discoveries to Toland's genius. He wrote that Dr. Toland discovered "an improved method of ligating arteries by which the danger of secondary hemorrhage was almost entirely eliminated from the after-effects of ligature. I allude to the use of the double ligature. . . . His success in the practice of this method was remarkable. I do not know the exact number of his operations, but I believe that in nearly sixty instances he lost but two cases from secondary hemorrhages.[5,6]

Toland ligated the subclavian artery three times,[6,8] once for axillary aneurysm and twice for aneurysm of the subclavian artery. These two were cases of distal ligature of the vessel, and were alleged to be the only two successful cases reported up to that time. Gross, of Philadelphia, in his book on surgery of that year (1874), reported the cases of nineteen patients all of whom died, seventeen from secondary hemorrhage. Toland reported six instances of ligation of the brachial artery and of these, two were for true aneurysm, three for false aneurysm, and one for a wound. He ligated the femoral artery eight times, three times for true aneurysm, twice for false aneurysm of the popliteal artery, once for a knife wound and twice for secondary hemorrhage. He ligated the external iliac artery ten times, without a death; more often, McLean stated, than any other surgeon. His ninth case was reported in 1878.[9] He ligated the common carotid artery in his office, with the patient in an armchair, and many times performed capital operations with the patient on his office lounge.

HIS BONE SURGERY

His bone work was perhaps his best. He operated on eleven patients and reported eleven cases of trephining of the cranium up to 1858 with but one death. In 1876, he reported four cases of disease of the temporal bone with caries of the mastoid process, in which operation was successful, several cases of excision and resection of long bones of the upper and lower extremities (in some of

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

Read before the Historical Section of the San Francisco Medical Society, January 11, 1938.

This is Paper VI of the series. For other articles in the symposium, see CALIFORNIA AND WESTERN MEDICINE, November, 1937, page 321; December, page 405; January, page 27; February, page 114; March, page 186; April, page 263.

** Part I of this paper appeared in the April issue, on page 263.

which curettement of the whole tibia, or two and one-half inches of the proximal end of the femur and part of the acetabulum was required), with good functional results, as well as several cases of amputation and resection.[7]

HIS ORIGINAL WORK

His most original work in this line was his article, "Reproduction of Bone," published in 1858. In this he reported seventeen cases of removal of diseased bone, and laid great emphasis on the preservation of the periosteum in order that new bone might be reproduced and amputation avoided. He wrote: "As the partial reproduction of bone has long been known, I only claim to have discovered that entire bones and joints are restored by proper management, even under the most unfavorable circumstances: whether they are as perfect as the original is yet to be determined. I know, however, that they possess sufficient strength and motion to subserve the purpose for which they were originally intended."

Duhamel, the discoverer of the osteogenic function of periosteum, had reported in 1739, that, in a case of necrosis of the humerus, the bone had been reproduced after expulsion of the necrosed diaphysis. Larghi, of Verceil, an Italian surgeon, following the theories of Duhamel, had been methodically saving the periosteum in his surgical operations. Ollier, in his textbook of regeneration of bone and subperiosteal resection, wrote he had found in 1858 that even after the removal of femur or humerus, reproduction of bone would occur if the periosteum had been saved, and that the joints would be reproduced if the articular cartilage had been left intact.[3]

AN ARDENT DUHAMELITE

Opposed to these views stood the opinions of the great Haller and the immortal John Hunter, both of whom agreed that "the normal periosteum had no bone-producing power" and acted only as "a passive vascular membrane which surrounded and nourished bone." Thus, in the eighteenth century, surgeons became Hallerites or Duhamelites, according to their views on this subject. It is clear that Toland was an ardent Duhamelite, and, like Syme and Macewen in their day, did much in this part of the world to emphasize the importance of conservation of periosteum, and thus prevent the amputation of limbs. Whether he came to his conclusions independently of the work of the European investigators mentioned above, I am unable to say, but this does not minimize the great contributions he made.

He reported three cases of excision of ribs for empyema. These were all drained by insertion into the chest of a silver tube invented in 1856 by Mr. Lindoff, his assistant, at the United States Marine Hospital. Some of these cases were of several years' standing. In these articles he gave a good clinical picture of penetrating wounds of the thorax, with the differential diagnosis, treatment, and prognosis.

PLASTIC SURGERY

In reading about his plastic surgery, whether of the nose, the face, the lips or the legs, one is impressed with his basic knowledge of the fundamental principles for success in this domain. He was thoroughly conversant with the pedicle, the sliding, and the Thiersh grafts, and was familiar with the necessity of securing drainage in order to permit the graft to take. From 1865 to 1876 he reported seventeen cases of plastic operations.

He was a very conservative surgeon, to the extent that he taught that "a limb should never be amputated for ulceration of the soft parts, unless disease of either the bone or joint existed, and very seldom even then."

GYNECOLOGICAL SURGERY

His gynecological operations ranged from repair of a vesicovaginal fistula to the excision of a fibrous tumor of the cervix of the uterus, and the correction of a prolapsed uterus by means of excising portions of the vagina and bringing the edges of the wound together, so that the caliber of the canal was diminished in proportion to the breadth of the strips removed.

LITHOTOMIES

His favorite operation was that for stone in the bladder. According to McLean, "His percentage of cures following lithotomy was higher than any other surgeon. In sixty-four cases of cutting for stone, he lost but two."

MEDICAL CONTRIBUTIONS

His formal addresses delivered to his students were simple, dignified and restrained, but replete with sound and lofty ideals. Although his teaching and his enormous practice occupied most of his time, he found opportunity to write seventy-one articles, mostly surgical case reports, a large number of which were published in the *Pacific Medical and Surgical Journal*. A stenographer took, verbatim, his lectures on the principles of surgery, as illustrated from his own experience. The transcriptions of these notes were published in 1877 as a textbook, entitled "Lectures on Practical Surgery," a work that went into its second edition. He did not confine his writings to surgical subjects, but often wrote on the action of drugs: for example, on the use of Monselle's solution (subsulphate of iron) as a hemostatic, and of American hellebore or Indian poke (veratrum veride) in slowing the action of the heart, reducing the force of the pulse, and thereby preventing secondary hemorrhage. The subject of syphilis always interested him, and he wrote nine articles on it. Also to be found among his addresses are several historical subjects, one on "The Life and Character of Valentine Mott." Although his articles and textbook were criticized by some of his colleagues, they reveal judgment, versatility, and sincerity. What he lacked in style, was compensated for by his straightforward description of his surgical procedures.

DECLINING YEARS

It is unfortunate that Toland, years before his death, did not relinquish his chair of surgery to his

brilliant and gifted pupil and successor, Dr. Robert A. McLean, who became one of the greatest surgeons that San Francisco ever has had. Toland carried on in his dotage after his luster had dimmed, which was, as always, a sad mistake. In those days, however, professors did not resign readily and give younger men with imagination and creative ability a chance. They tenaciously clung to their chairs. They liked to die, so to speak, in harness, and often by that time their successors also had become senile, losing their initiative.*

In his declining years Toland's lectures became a peculiar combination of his experiences in the days when he "walked the Salpetriere in Paris with the great surgical masters," personal anecdotes, and reminiscences of his controversial differences with his San Francisco confrères, with whom he had carried on a fratricidal war for many years. His chief antagonist and critic was Elias Samuel Cooper, who had organized a medical school in 1858. They were bitter enemies, and no opportunity to clash was lost by either, in private practice or in lawsuit. It must be remembered that this was the militant period of medicine, when feeling ran high. Toland was a strong man and a powerful enemy who gave no quarter and asked none. "There were giants in those days" and Toland was not the least of them.

DEATH COMES TO THE GREAT SURGEON OF THE PACIFIC COAST

He had often expressed the hope that he might not die a lingering death. This hope was realized on the morning of February 27, 1880. He was about to go downstairs to begin his day's work, when he fell to the floor and immediately died. No autopsy was performed. It was assumed that he had fainted and then fallen, striking his forehead and thus causing a cerebral hemorrhage. I am informed by some who attended his funeral that it was the largest ever held in San Francisco. Thousands of friends and grateful patients followed his remains to Laurel Hill, where he lies in one of the most stately mausoleums in that cemetery. And there one of his former students went again after many decades to pay his respects, and later told me, "I stood beside his costly marble monument blazoned with legends of his successes and the great reputation he acquired, and the good deeds that enshrine his name, with a deep veneration for the good he had done, and the great accomplishments for which his name now justly stands."

He was survived by a widow, a son, and a stepson. His estate was estimated as amounting to between one and a half and two million dollars, part of which was 15,000 acres of land on the lower Sacramento River.

A FRIEND OF ALL MANKIND

In order to evaluate the greatness of any physician it is necessary to bring him into proper alignment with the period of medicine through which he lived, and of which he was a part. In Toland's day, asepsis in surgery was unknown, and the washing of hands was not even suggested. Pasteur's discoveries were not yet appreciated, and the ideas of Lister, just then being introduced, were considered a joke. Koch had not yet discovered the first germ, nor Roentgen the x-rays. The cause of tuberculosis, syphilis, malaria, typhoid fever, diphtheria, and, in fact, infectious and contagious diseases in general, were still matters of conjecture. These were the days when doctors pronounced; it was a time when medicine was an art, not a science. Little wonder that physicians needed personality to help them in their everyday problems. In their saddlebags they carried none of the armamentarium of the graduates of modern medicine; nevertheless, the great physicians of that day cured some, alleviated the distress of many, and sympathized with all. They were, indeed, the friends of all mankind.

BELOVED BY HIS PATIENTS

Years of observation have forced upon me the conclusion that the careful preparation and long years of diversified clinical teaching and laboratory training do not, in many cases, make the doctor and that, perhaps, after all, it is the *man* who is the successful physician. Our young doctors today know little of the tongue and its proper reading, nor is the feel of the pulse impressed upon them. Above all they know little of the art of medicine, though much of its science; and often, the diagnosis having been determined—correctly or incorrectly—they consider their duty to the patient done. They know little of the power of suggestion and the wonders that may be accomplished by personally inspiring their patients. In these aspects of medicine, Doctor Toland was a master and, although his method was often condemned, he cured his patients and retained their veneration. He belonged to a generation of surgeons which is rapidly passing into history. The general surgeon of his day occupied a place in surgical science and in the hearts of the people which the specialist can never fill; and this is one of the dire penalties of specialism.

A PATRON OF SCIENCE

Hugh H. Toland, by his ability as a surgeon, his capacity as a teacher, his contributions to the medical and surgical literature of his day, and his dominant personality was, when he came to die, perhaps the most outstanding figure in medicine not only on the Pacific Coast, but in the West. Today we are permitted to obtain a perspective of him and his achievements. As years have grown into decades, and now, as a full half-century has rolled by, his name looms larger than ever, while most of his bitter and shallow contemporaries, who made light of his achievements, have faded into obscurity. His name will rightfully live as that of a patron of science and learning on the Pacific Coast.

384 Post Street.

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ADDENDUM

LIST OF THE CLINICAL CONTRIBUTIONS OF HUGH HUGER TOLAND, M.D. (1806-1880)

(For list see back advertising section, page 45 in this issue)

CLINICAL NOTES AND CASE REPORTS

HEMOPOIETIC APLASIAS FOLLOWING THE ARSPHENAMINS, WITH TWO CASE REPORTS

By WILLIAM E. GRAHAM, M.D.
AND
NORMAN H. TOPPING, M.D.
San Francisco

DURING the past few years the arsphenamins have been belabored because of untoward results occurring during the treatment of syphilis. Among these unlooked-for complications, changes in the hemopoietic system, due to the arsphenamins, have more and more been frequently mentioned. This increasing accumulation of literature is probably due in part to several masterful articles appearing during 1932. McCarthy [1] and Wilson published a summary of the literature, and cited two cases of symptomatic theombocytopenic purpura at about the same time that A. B. Loveman [2] also reviewed the literature and added several cases of varied types of blood reactions due to the arsphenamins. These conditions are rare, however. Cole [3] and his coworkers observed only two cases of blood dyscrasias in a total of 338 complications arising in the treatment of 1,212 patients over a ten-year period. Phelps had two cases in 272,354 injections, and Combs one in 4,000 patients. The following two cases have occurred in our antiluetic clinic in some 23,000 injections over a period of six years.

REPORT OF CASES

CASE 1.—T. A., a seaman, white, age forty-two, reported at the outpatient clinic of the Marine Hospital at San Francisco, California, on October 7, 1935, complaining of a penile lesion which had been present, off and on, for the past six months. Blood was obtained for a Wassermann test on that date. The Noguchi antigen was one plus, the cholesterin antigen was four plus, and the Kahn test was positive. The patient stated that he had had no previous treatment. He had gonorrheal urethritis in 1931.

As no contraindications were present, antiluetic therapy was started at once, with prompt healing of the penile lesion. During the course of his outpatient treatment he received twenty-one intramuscular injections of bismuth, totaling 3.15 grams, and twenty-one intravenous injections of neoarsphenamin, totaling 8.55 grams.

On January 15, 1936, however, after receiving his treatment, he complained of nose-bleeds, which had been occurring off and on for the past two weeks. He had also had a cold, with cough, for one week. He was at once sent to the ear, nose, and throat clinic, where a small oozing point was discovered on the septum. The nose was packed with cocain-oxycyanid, the packing being removed on the following day. He returned on January 20, four days after this, when he stated that the bleeding had reappeared and had become almost constant. He was admitted to the hospital on the medical service.

On admission, the patient's only complaints were bleeding from the nose and a cold with coughing. Physical examination revealed the following significant findings:

A moderately obese white male, quite apprehensive, with clotted blood on his lips and bright red blood oozing from his nares.

Eyes: Conjunctiva injected. Definite icteric tint to sclerae. Pupils equal and regular, and react to light and in accommodation. Extra-ocular movements normal.

Nose: Both nostrils filled with fresh blood-clots. Blood oozing from under clots. No bleeding points seen after clots were removed.

Mouth: Lips coated with dried blood. Tongue coated. Petechial spots on palate and on buccal mucous membrane. Pharynx injected and tonsils atrophic. Several ulcerative lesions on uvula and soft palate.

Neck: No adenopathy present.

Heart: Apex impulse in fifth interspace one centimeter outside midclavicular line, rate 68, regular rhythm. No thrills. Soft, blowing systolic murmur heard at aortic area. Blood pressure, 120/80.

Lungs: A few subcrepitant râles heard scattered throughout both lung fields. Otherwise examination was negative.

Abdomen: Obese. No scars, hernias, masses, tenderness, or rigidity. Liver not enlarged or tender. Spleen barely palpable.

Extremities: A few small petechial spots on the right arm and under several fingernails of both hands.

Laboratory work and treatment were immediately started, using the following possibilities as a working diagnosis:

1. Arsenical reaction.
2. Blood dyscrasia.
3. Bacterial endocarditis.

The appended chart indicates the blood picture from day to day, with the accompanying treatment:

COMMENT

The blood culture was found to be negative, and as there was a history of intensive arsenical treatment for the past three months, it seemed evident that the accompanying blood dyscrasia could be best explained on a basis of neoarsphenamin as the etiologic agent. Due to the marked reduction in polymorphonuclear cells, agranulocytosis was thought of at once. There was, seemingly, one serious discrepancy in this diagnosis,

CHART 1.—*Day by Day Blood Picture*

Date	R. B. C.	W. B. C.	Hgb.	Plate	Differential	Remarks
1/20/36	4,100,000	4,400	75%	16,190	Polys 20 S. Lymphocytes 40 L. Lymphocytes 10 Transitionals 30	Icteric index 45 Bleeding time 13 Coagulation time 5 Blood culture Negative
1/21/36		3,000			Polys 15 S. Lymphocytes 18 L. Lymphocytes 37 Transitionals 30	Liver extract started by mouth. Pentnucleotid 10 c. c. I. M.
2/22/36	4,100,000	2,900	73%	2,400	Polys 5 S. Lymphocytes 20 L. Lymphocytes 35 Transitionals 10	Pentnucleotid 30 c. c. I. M. Blood transfusion 480 c. c.
2/23/36	4,760,000	6,000	83%		Polys 20 S. Lymphocytes 10 L. Lymphocytes 40 Transitionals 30	Pentnucleotid 30 c. c. I. M.
2/24/36 9:00 a. m.		1,500		500	Polys 0 S. Lymphocytes 18 L. Lymphocytes 42 Transitionals 40	No normal W.B.C. seen—all showing marked degeneration. Pentnucleotid 20 c. c. I. M.
4:00 p. m.	4,240,000	3,400	63%		Polys 20 S. Lymphocytes 32 L. Lymphocytes 36 Transitionals 8 Rosin 4	Blood transfusion 210 c. c 26 3:00 p. m. Patient expired at 12:00 midnight.

namely, the tremendous reduction in the blood platelet count, with the accompanying hemorrhagic diathesis. As the case was further studied, however, it was realized that arsphenamin may produce not only an agranulocytosis, but also a thrombocytopenic purpura, and even a complete aplasia of the bone marrow. The patient was, therefore, believed to have a combination of agranulocytosis and thrombocytopenic purpura, the etiologic agent being neoarsphenamin.

In considering the proper treatment to be employed, the question arose as to the extent of damage in the bone marrow. If an aplastic anemia were present the prognosis was, of course, exceedingly grave. There was, however, at no time any definite indication of this, the red-cell count never dropping below 4,000,000 in spite of continuous oozing of blood from the mucous membranes of the nose and throat and, probably, the intestinal tract. We believed, therefore, that we were justified in using large doses of pentnucleotide in combination with blood transfusions and liver extract. In spite of these measures, the bleeding became progressively worse, the polymorphonuclear cells dropped to zero, the blood platelets dropped to 500 centimeters, and the patient died at midnight on February 24, 1936, after being in the hospital less than five days.

NECROPSY REPORT

An obese white male, 65 inches tall, hair tinged with gray. There is a frothy, bloody fluid running from the nose and mouth. The pupils are contracted. Marked subconjunctival hemorrhage in both eyes. No external lymphadenopathy.

Chest: No fluid or adhesions in either pleural cavity. Lungs normal, except for hypostatic congestion of the bases.

Heart: Pericardial sac contains 50 cubic centimeters of clear serous fluid. Several petechiae are present on the epicardium. The left ventricle is pale, and hypertrophic. The valves are normal and the coronary orifices are patent. There are mild luetic changes in the intima of all parts of the aorta. The heart weighed 440 grams.

Abdomen: Obese wall. Tissues show icteric tint. Intestines distended with gas. Numerous purpuric areas present in the lower five feet of the ileum. The lumen contains black, tarry material, evidently partially digested blood.

Spleen: Weighs 240 grams. Is about twice normal size, dark mahogany in color, with numerous petechiae on the surface. It is mushy in consistency and, on sectioning, the surfaces are dark red with areas of hemorrhage present.

Liver: Petechial hemorrhages scattered over the whole surface. Sections show gross hemorrhages interspersed between yellow areas, suggestive of fatty degeneration.

Stomach: Contains about 300 cubic centimeters of a dark, bloody fluid. There are numerous petechial hemorrhages in the mucous membrane along the greater curvature.

Kidneys: Normal size. Both kidneys congested. The capsule strips easily. Petechial hemorrhages are present over the surface. In the cut surfaces the cortex is congested and edematous. Numerous hemorrhagic areas are present throughout the parenchyma.

Bone marrow: Pale in color. Microscopically, there is no evidence of any attempt at regeneration. Normoblasts greatly reduced per oil immersion field. Myelogenous series markedly reduced and very toxic in appearance, vacuolated, with no mature cells seen.

Pancreas, bladder, testicles and prostatic gland are normal.

* * *

CASE 2.—C. M., a seaman, white, age twenty-four years, entered the Marine Hospital at San Francisco, California, on November 28, 1934. He complained of a urethral discharge and penile sores. His family and personal history were not significant. He denied having taken coal-tar derivatives or any additional medication other than the antiluetic treatment mentioned below. Twenty-eight days previous to admission he developed two small ulcers on the penis. He reported to a physician in Los Angeles, who found the blood Wassermann four plus. The patient was given one cubic centimeter of bismuth in oil on November 5, 8, 13, 19, and 26, 1934, and 0.9 gram of neoarsphenamin on November 8, 15, and 22, 1934.

Upon admission to this hospital, physical examination revealed a very robust individual whose only positive findings were healing penile ulcers, enlargement and tenderness of the inguinal glands, and an enlarged and painful prostate. The Noguchi and cholesterin antigens were four plus; the Kahn test was positive. The patient was placed on hot sitz baths, and was given 0.1 gram of arsphenamin and 0.15 gram of bismuth salicylate on December 1 and 5, 1934. He developed a yellow tinge to the sclerae on December 6, 1934; the icteric index was 20 units. The antiluetic treatment was discontinued.

CHART 2.—*Blood Counts in Case 2*

Date	R. B. C.	W. B. C.	Hgb.	Plate	Differential	Remarks
12/9/34						Redness and swelling of gums. Temp. 100.5 F.
12/12/34	5,020,000	4,000	102%	Normal	Polys 0 S. Lymphocytes 54 L. Lymphocytes 30 Transitionals 14 Basophiles 2	Temp. 105 degrees F. Pentnucleotid. 100 I. M. twice daily.
12/19/34	5,000,000	1,800	92%	Normal	Polys 40 S. Lymphocytes 50 L. Lymphocytes 5 Transitionals 5	Temp. normal.
1/3/35	4,890,000	9,600	85%	Normal	Polys 46	Ground liver t. i. d. Up to this time a total of 390 c. c. of pentnucleotid had been given.
1/4/35	4,900,000	11,100	93%	Normal	Polys 63	Pentnucleotid discontinued.

On December 9, 1934, the patient complained of a cold and sore throat. Examination revealed redness and swelling of the gums. The temperature was 100.5 degrees Fahrenheit. Sitz baths were discontinued and the patient was treated expectantly. On December 12, 1934, the mucous membrane of the mouth was diffusely inflamed, and there was a grayish, adherent membrane over the hard palate and gums. The temperature had risen to 105 degrees Fahrenheit. Except for bilateral swelling and tenderness of the submaxillary lymph glands, the physical examination was negative. A culture of the throat smear revealed long chain streptococci and M. catarrhalis; blood culture revealed no growth. Blood counts are recorded in Chart 2.

A diagnosis of agranulocytosis was made. The patient was given normal warm saline irrigations to the throat several times daily, a liquid diet, and a sufficient amount of codein to insure rest. Pentnucleotid (10 cubic centimeters) was administered intramuscularly twice daily.

Pentnucleotid therapy was discontinued on January 14, 1935. This was followed by five doses of iodobismitol; two cubic centimeters was given intramuscularly twice a week for five doses. The percentage of granulocytes decreased from 63 to 36. Pentnucleotid was given again and the iodobismitol was discontinued. The white count returned to normal by January 27, 1935. Mercury inunctions were started and continued three times weekly. The patient felt well and was discharged as fit for duty on May 29, 1935. He was advised to continue the mercury inunctions while he felt well, and to report as an outpatient from time to time for further observation.

The following are some other points of interest in the case. The blood Wassermann test on December 17, 1934, was negative in the Noguchi and cholesterinized antigens, but positive in the Kahn. On March 7, 1935, and April 22, 1935, the blood was negative in all antigens. On May 9, 1935, the spinal fluid examination was entirely negative.

This same patient reported to the outpatient clinic one year later, on April 10, 1936, with a large furuncle on his leg. The white count was 18,000, with 80 per cent polymorphonuclears, showing that he had not suffered any permanent damage to his hemopoietic system.

COMMENT

The two cases reported from this hospital during the past year were direct results of neoarsphenamin therapy in the treatment of syphilis. In the first case here reported, both neutropenia and thrombocytopenia were outstanding findings. Furthermore, postmortem examination plus microscopic studies of the bone marrow indicated an early aplastic anemia. As would be expected from these findings, the case terminated fatally in spite of intensive therapy, consisting of pentnucleotid, liver extract, and blood transfusions.

In the second case, however, in which neutropenia was the only change in the blood picture, there was an excellent response to the pentnucleotid therapy, and the patient had completely recovered when he was discharged from the hospital.

DISCUSSION

The mechanism by which the arsphenamins cause changes in the blood picture is rather vague. Syphilis apparently has no relation to the etiology of agranulocytosis. Culley et al.[4] reported a case following neoarsphenamin therapy in which the patient was not affected with syphilis. It is a well-known fact that both benzene and arsenic cause bone-marrow depression, Kracke[5] having been able to produce agranulocytosis in rabbits by administering benzene subcutaneously; and, since arsphenamin combines these two drugs, we have a compound which may act as a very strong etiologic agent.

The cases of blood dyscrasias following the arsphenamins can be classified as follows:

Class 1. *Thrombocytopenic.* Purpura and external bleeding are constant symptoms and occur within a few hours to days after the last injection. Reduction in the number of platelets is the outstanding feature.

Class 2. *Neutropenic.* Fever, sore throat, and necrotic lesions of the pharynx are the commonest symptoms and findings clinically. The blood picture reveals a great diminution to total absence of the neutrophilic leukocyte.

Class 3. *Thrombocytopenia and Neutropenic.* Purpura, external bleeding, fever, sore throat, and necrotic lesions of the pharynx are all clinically marked. The blood picture is a combination of Classes 1 and 2—revealing a marked reduction in platelets, plus a diminution to total absence of the neutrophilic leukocyte. The red cells, hemoglobin, and lymphocytes, all remain within the normal range.

Class 4. *Aplastic.* This represents the largest group in the literature and is the most serious. The symptoms and clinical findings are varied, ranging from pallor to purpura or bleeding. The blood picture indicates a depression of all the

circulating blood elements, red cells, hemoglobin, platelets, etc.

The prognosis depends upon the amount of bone-marrow depression. The thrombocytopenic group offers the best prognosis, as they almost invariably recover when this is the only change in the blood picture. The cases of neutropenia may be expected to recover as long as there is not a total absence of polymorphonuclear cells. The group in which there is both neutropenia and thrombocytopenia offers a more serious prognosis than either of the two separate types. As shown in Case 1, which clinically fell in this group, while postmortem examination indicates a decided aplasia of the bone marrow, the prognosis may be that of aplastic anemia which, of course, is exceedingly grave, the literature revealing a mortality of 83 per cent, when, clinically, the diagnosis of true aplastic anemia was made.

IN CONCLUSION

The blood dyscrasias, although quite rare, are of sufficient interest and importance to be kept constantly in mind in any clinic where extensive antiluetic therapy is being conducted. We are reporting two cases which have occurred during the past year at the Marine Hospital in San Francisco.

Attention is called to the fact that when either purpura, external bleeding, sore throat, necrotic pharyngeal ulcerations, or pallor are present during the course of arsphenamin therapy, the blood picture should be immediately studied with one of the dyscrasias as the diagnostic possibility, and the appropriate therapy instituted without delay.†

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POTASSIUM IODID: ITS USE*

By Fred Baker, M.D.
Point Loma

AT eighty-four I have long been retired from active practice, but a few of my old patients still come to me for slight attention. Having specialized somewhat in diseases of the eye, I occasionally fit a pair of glasses.

So long out of practice, there would seem to be little of value which I could offer to a younger generation of physicians trained in newer methods of practice of which we scarcely dreamed. Yet it does not happen to many members of the profession to observe individuals as I have done in a few cases over a term of more than forty years. Some such observations seem worth while putting on record.

My thesis is the proper and improper use of that old and tried remedy, potassium iodid, which, as it appears to me from reports among my younger friends, is too much neglected in favor of newer drugs, often less efficient than this old reliable one. I trust I may be pardoned for a report on my personal experience.

When I was a medical student I developed a small opacity of the vitreous humor of the right eye. Doctor Frothingham of the eye department wrote me his regular prescription—a dram of iodid of potassium in an ounce of water, a teaspoonful to be taken three times a day, thus giving about seven and a half grains at each dose. I took it for about four days, when I developed an intensely sore throat and had to stop the drug. Naturally, it did no good in so short a time.

About thirty years ago this same opacity apparently increased in size so rapidly that I suspected a retinal hemorrhage. I am not sure whether the opacity actually increased in size or simply shifted its position more directly into the line of central vision. I immediately resorted to my old remedy, the iodid. Forgetful, however, of my former experience, I took ten drops of a saturated aqueous solution of the drug three times a day, about eight grains at each dose. It did splendid work with the opacity, which disappeared almost entirely within a short time, but I found my health failing so seriously that I spent about two months in bed with a rapid and irregularly acting heart and great general depression. None of our local doctors would venture a diagnosis, and I got out of bed with badly impaired health, which has greatly lessened my activities ever since.

It was about a year before any definite diagnosis was made. Then, at a meeting of the State Medical Society, I met Dr. Martin Fisher, who later went to the Medical School of the University of Cincinnati as professor of physiology. He diagnosed the case at once, assuring me that the condition was just being recognized; that there were less than a dozen cases then on record. He said that the overdosage of potassium iodid had brought on a hyperthyroidism, in my case showing only an extreme tremor and irregular heart action with depression, without the usual exophthalmia and enlargement of the thyroid. I have not kept up with medical literature for many years and the condition may be a well-recognized disease now, but it was almost unknown when I acquired it.

Curiously, I had been following a routine with all of my patients for several years which, most unfortunately, I failed to practice in my own case. I always prescribed a saturated solution of the iodid and, beginning with one, or at most, two drops, increased the dose a drop a day if there were no hurry; a drop at a dose three times daily if the case

† We wish to acknowledge the courtesy of Drs. F. C. Stewart and E. L. White, in furnishing the data on our second case.

* These personal observations by a pioneer physician of San Diego, Dr. Fred Baker, known to many of the older members of the California Medical Association, should be of interest. See also Doctor Baker's letter on page 380.

was urgent. But as I was foolish enough to believe that I could stand any reasonable dose, and the case seemed most urgent, disastrous results followed.

Surgery, possibly, offers the best opportunity to observe direct results of treatment. But in internal medicine I believe there is no condition where the physician can so certainly and accurately gauge the effects of his medicine as in observations of the internal anatomy of the eye. In cases of retinitis, choroiditis, vitreous opacity, and cloudy aqueous humor, the oculist prescribes his drugs, and with his ophthalmoscope can observe the results from day to day or from week to week. It has been my good fortune to watch a great number of such cases, some of them through long terms of years.

Recurring to my method of determining the patient's tolerance of the drug, I have found two symptoms of overeffect which seem to be of paramount importance—the induction of a sore throat and loss of appetite, often with severe vomiting. At the first appearance of either of these symptoms, the dose should be well cut down and a very slow approach begun again to find just how much of the drug can be given, generally three times a day, without any disturbance. This dosage can usually be continued indefinitely.

I recall one case of my student days which should have waked us up to the facts here stated. A man about forty, who could not see light in either eye, came to the clinic. His vitreous was so clouded that no red reflex showed on ophthalmoscopic examination. Doctor Frothingham again prescribed his usual dose of the iodid, seven and a half grains, three times daily. After three or four days the patient had severe vomiting, lasting two days. After about five days Dr. Frothingham repeated the same dosage with the same results. I do not know how often this happened, but at the end of a few weeks the opacity in both eyes had cleared absolutely, giving a perfect view of the fundi. But still the patient could not see light. The fundus was scarred all over from what evidently had been an intense chorioretinitis, leaving absolute blindness in its wake. I do not recall whether there was luetic infection in this case, but I believe it does not make much difference. The iodid should be given in all cases where there is an inflammation leaving any amount of deposit in the tissues of the eyes. Observation would simply tend to show that in luetic cases the effect is likely to be more prompt and more startling than in cases where such infection is absent.

It has been my good fortune, many times, to have given iodid of potassium in cases of retinitis, choroiditis, and vitreous opacity, and to have been able to watch, with the ophthalmoscope, the gradual disappearance of the deposit to more or less complete recovery. A case in point: that of a youngster in the grade schools, who came to me professionally over forty years ago for an acute retinitis. His vision was down just below 20/70. As usual, I gave the iodid and ordered the use of atropin and dark glasses. The first time the treatment lasted nearly three months, during which he kept up his school work with the help of his mother. For several years he had frequent recurrences of the trouble, each time with more or less loss of vision and more or less deposit in the retina. I have watched these deposits clear up time and again under the influence of the iodid. After each attack his vision was normal, and it has continued so to the present time. The eyes are strong and he has had no recurrence since his university days. Then he had two attacks and was treated by Dr. A. Barkan, along the same lines that I had tried, with the same results. But he lost so much time that he gave up endeavoring to finish his university course. I have had this patient under observation during all the intervening years, and he still comes to me for changes of glasses. Today he has normal vision in each eye, and the eyes are strong. I greatly doubt if any other treatment than that used could have given the same results.

A curious concomitant of this case puzzles me. When about three years old, this patient had measles with a severe myocarditis as a complication. It left him with one of the loudest mitral murmurs that I have ever heard. This lasted into adult life; but perfect compensation has since taken place and he was accepted by an old line insurance company for a policy of $10,000 about sixteen years ago, although he gave the examiner a history of the old heart murmur. We have all seen more or less compensation take place in such cases, but I have never seen such complete recovery as in this case. I have long believed that the continued dosage with the iodid was a very large factor in this change. Of course, this is not susceptible of proof, but I report it for what it is worth.

As to the difference of toleration, I have seen one case with vision down to 20/40 where distinct retinal deposits disappeared under the influence of a single drop of the saturated solution three times a day; and I had two cases of paresis of the extrinsic muscles of both eyes, with a history of old syphilis, in which I gave a teaspoonful of the saturated solution three times a day without any symptom of overdosage. One patient made a perfect recovery, which continued during about six years that I had him under observation. The other, a professional strumpet, was not affected by the treatment.

Recurring to my own case, I have found that I bear four drops of the iodid solution three times a day. I can continue this dose indefinitely, but five drops almost immediately brings on severe sore throat and nausea.

I have not kept up with medical literature of late, so do not know how far anyone has preceded me in any of the conclusions here drawn. But I have talked with many physicians through the years and find a lot of them following the old and dangerous practice of giving a set dose of the iodid to all patients. In some cases this can very seriously damage the patient; in others it will prove absolutely inert and there will be another physician without any faith in potassium iodid, one of the most reliable remedies, however, in our armamentarium.

Point Loma.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

THE MYOMATOUS UTERUS

I. DIFFERENTIAL DIAGNOSIS AND TREATMENT

CLARENCE W. PAGE, M.D. (2560 Bancroft Way, Berkeley).—*Diagnosis.*—The diagnosis of an uncomplicated myomatous uterus of fair size is one of the simplest in gynecology. A hard, irregular tumor occupying the mid-abdomen is characteristic, and bimanual examination shows the mass to be intimately connected with the cervix. However, in some cases the tumor is more uniform and at times quite soft. Single, pedunculated fibroids may be more difficult to distinguish from tumors arising in other structures.

When the myoma does not distort the uterine cavity there is not likely to be any disturbance of the menstrual flow, and the symptoms are mainly those due to pressure on the other abdominal organs. When the myoma grows into the uterine cavity the menstrual flow is usually increased in both amount and duration. If the myoma should become an intra-uterine polyp, bleeding may be intermenstrual in type as well as menorrhagic.

Pregnancy is the commonest abdominal tumor and must always be considered. It must be remembered also that pregnancy and fibroids frequently coexist. When both conditions are present, there will usually be some areas which are definitely softer than in an uncomplicated fibroid. Amenorrhea is the rule in pregnancy and rare in fibroids. Associated symptoms of pregnancy may make one suspicious at once of the possibility of pregnancy. No patient in whom there is any question of the existence of pregnancy should be operated upon unless the hormone test has been done. Notwithstanding this, nearly every surgeon of experience has occasionally opened an abdomen only to discover what very closely resembles a pregnant uterus. Several points will aid in preventing either the removal of a pregnant uterus or closure in the mistaken idea that one is dealing with a pregnancy. One of these points is the relationship of the tubes and round ligaments to the fundus. In pregnancy the normal relationship is preserved, while in myoma it is likely to be disturbed. In pregnancy, search of the ovaries may reveal the presence of a corpus luteum of pregnancy, while this will be absent in myoma. Finally, aspiration of the tumor may disclose the presence of amniotic fluid, and this procedure is not injurious should pregnancy be present.

Extra-uterine pregnancy, particularly an abdominal pregnancy with formation of a lithopodium, may closely simulate a myoma. The history, if carefully taken, will be suggestive and an x-ray examination will usually reveal the true condition. I have seen operation undertaken under such circumstances. Surgery is indicated anyway, but the mistake may be embarrassing.

Ascites may resemble an abdominal tumor. The dullness is in the dependent portions with tympany in the mid-abdomen while recumbent. The reverse is true in myoma. The dullness also changes with change of position and a fluid wave may be demonstrated. While ascites may accompany fibroids, it is very rare unless due to associated cardiac or renal failure, and these conditions should easily be shown.

Ovarian cysts usually present no great difficulty in differentiation. When the cysts are thick-walled, they may cause some confusion. Malignant cysts, especially when there are solid metastases in the omentum, may closely simulate a myomatous uterus. The frequent association of ascites under these circumstances and its rarity in myoma will assist, and a careful history and palpation of the tumor may settle the question.

Chronic pelvic inflammatory masses, when large and adherent to the uterus, may cause some confusion. Usually a history of previous pelvic inflammation can be obtained. There will commonly be some increase in the white blood count, decrease in the sedimentation time, some elevation of the temperature and more tenderness than is found in myoma. The frequent association of pelvic inflammation and myoma is important to remember. Witherspoon says that his experience has demonstrated the almost universal association of the two conditions in colored patients. I agree that it is very common under these circumstances, but my experience would not justify so extreme a statement. As radium is contraindicated in the presence of pelvic inflammation, the association of the two is important to bear in mind.

Torsion of a pedunculated fibroid is a possibility, though rare compared with the frequency of torsion of ovarian cysts. The symptoms are similar to those presented by torsion of an ovarian cyst, or even of a hydrosalpinx, and a definite differentiation may be almost impossible preoperatively. The diagnosis of an acute surgical abdomen is frequently the preoperative diagnosis.

The development of sarcoma in a myomatous uterus may be suspected if the growth be rapid. Otherwise it is impossible to detect it, unless it should invade the uterine cavity. It would then cause irregular bleeding, and a diagnostic curettage and biopsy would make the diagnosis.

Carcinoma of the uterus rarely presents great difficulty in differentiation. The myomatous uterus seldom bleeds unless the uterine cavity is involved, and then the bleeding is usually menorrhagic in type. The bleeding in carcinoma is usually metrorrhagic. Any patient who is supposed to have a myoma in which there is any vaginal bleeding should be subjected to a preliminary diagnostic curettage with biopsy.

As in carcinoma, the uterine bleeding associated

with hydatidiform mole and chorionepithelioma will ordinarily prevent confusion.

A mole has a short period of amenorrhea and other symptoms suggesting pregnancy preceding the onset of bleeding. The rapid growth of a soft tumor is suggestive, and if the characteristic grape-like portions of the tumor are passed, the diagnosis is certain. Chorionepithelioma usually follows mole or occasionally abortion, and in those cases which I have seen, the enlargement of the uterus has not been great. As bleeding is present, diagnostic curettage is indicated and will reveal the condition. It should be remembered that both of these conditions show a positive hormone test in high dilutions of the urine.

A myoma developing low on the posterior surface of the uterus may simulate a retroverted uterus. If the fundus cannot be palpated anteriorly, and there are no contraindications to the procedure, the passage of a uterine sound may show the true relationships.

If the myoma develops between the layers of the broad ligament, the distinction between it and a solid tumor of the ovary may be difficult, unless the ovaries can be palpated independently of the tumor.

Intra-uterine and cervical polyps present other diagnostic and therapeutic problems. This phase is being set forth by another essayist.

Near the menopause we sometimes encounter a moderate increase in the size of the uterus due to a general replacement of the muscle tissue by fibrous tissue. It will not often cause difficulty in diagnosis except when considering submucous myomata. As bleeding is the compelling symptom, diagnostic curettage is indicated. Delicate manipulation of the curette will reveal the soft velvety feel of malignancy, the hard smooth surface of general fibrosis or the irregularity present in submucous myomata.

Treatment.—In discussing treatment it is important to rememebr that many myomata are relatively symptomless and require no active treatment. Under such circumstances the patient should be urged to report once or twice yearly for examination, and immediately if symptoms develop. If the tumors are not increasing in size or producing symptoms, they may be left alone.

Diagnostic curettage and biopsy should precede or accompany any form of treatment if there is any bleeding.

The methods of treatment available at present may be enumerated as follows: (1) Subtotal abdominal hysterectomy; (2) Total abdominal hysterectomy; (3) Radiation with either x-ray or radium; (4) Abdominal myomectomy; (5) Vaginal hysterectomy; (6) Vaginal myomectomy; and (7) Removal of polypoid tumors through the vagina.

Subtotal abdominal hysterectomy is the commonest procedure. For the technique of this operation and the many modifications, the reader is referred to standard texts. The disposition of the ovaries will need consideration. In younger women the preservation of at least one ovary is desirable if ample circulation can be assured. Removal of the associated tube will frequently prevent ample circulation and cystic degeneration is likely to follow, necessitating additional surgery later. Should it be thought best to remove both ovaries, consideration should be given to the advisability of implanting portions of an ovary, cut into small fragments, in the rectus muscle.

Some surgeons advocate total hysterectomy in all cases. This is based on the fear of the development, or possibly of overlooking, carcinoma in the retained cervix. The skillful surgeon will not materially increase his mortality by practicing routine total hysterectomy. In the hands of the occasional operator, however, the increased risk of the total over the subtotal operation may more than offset the risk of cancer. If the cervix is seriously diseased, it should certainly be removed. An alternative procedure is the deep destruction of the endocervix by the electrocautery as a preliminary step, or the removal of the same from above after amputation of the tumor.

Treatment by x-ray or radium in properly selected cases is an efficient method. Baer *et al.* state that in the Michael Rees Hospital 15 per cent were treated by radiation in 1923, but that in 1933 the number was reduced to 2.1 per cent. Diagnostic curettage and biopsy must always precede or accompany this form of treatment. It is particularly adapted to the tumor not larger than the size of a twelve to fourteen weeks' pregnancy in women over thirty-five years of age. In younger women the menopausal symptoms may be so severe as to cause regret. The patient who is a poor operative risk may be better treated by radiation in many cases, especially if bleeding is the prominent symptom. The bleeding is checked in a high percentage of cases and slow regression of the tumor often follows. Tumors which are causing pressure symptoms or pain are not favorable for treatment by radiation. Pedunculated fibroids and tumors undergoing degeneration present unfavorable conditions. Rapidly growing tumors are better treated by surgery. Chronic pelvic inflammation is unfavorably influenced by radiation, so if there is any suspicion of its presence, surgery is preferable. Pregnancy contraindicates radiation unless the pregnancy is to be terminated at the same time.

The effect of radiation is probably an indirect one, dependent on the effect of the rays on the ovaries. The dosage must, therefore, be sufficient to cause permanent amenorrhea. Two thousand milligram hours of radium, or its equivalent in x-ray, will usually suffice. Proper screening of the radium, firm packing of the vagina, and prevention of a full bladder are some of the necessary precautions. In young women, when it is desired to preserve the child-bearing function, myomectomy may be the operation of choice. It should be restricted to interstitial, subperitoneal, and pedunculated fibroids where the number of tumors is not large. There is considerable risk that some small tumors may be overlooked and necessitate hysterectomy later. It is inadvisable, therefore, unless the desire for pregnancy outweighs the risk of recurrence.

Vaginal hysterectomy in the hands of one skilled in this method of approach is quite satisfactory, provided the tumor is not too large to be delivered

easily through the vagina. Larger tumors have been operated upon by this route, but the technique is difficult and the advantages questionable. Myomectomy may also be done by this route, but I believe it to be inferior to the abdominal approach.

Removal of intra-uterine and cervical polyps through the vagina is sometimes a simple procedure, but in other instances they are preferably treated by hysterectomy. In removing a large extruded polyp, one should rule out the possibility of a chronic inversion of the uterus, for vaginal hysterectomy should be premeditated and not accidental.

* * *

II. THE EFFECT OF FIBROMYOMAS ON LABOR

Donald G. Tollefson, M. D. (511 South Bonnie Brae Street, Los Angeles).—The dystocia produced by fibroid tumors will depend upon their size and situation. While the incidence of this type of tumor in pregnant women is conservatively estimated between 5 to 10 per cent, those of sufficient size to give rise to complications in labor is probably less than one per cent of all obstetrical admissions. The three conditions most often encountered when labor occurs in myomatous uteri are as follows:

1. Obstruction to the birth canal.
2. Increased occurrence of abnormal presentations (such as breech and transverse).
3. Uterine inertia.

It is extremely difficult to prognosticate the end-result, for frequently a tumor which seems to present a definite obstruction is withdrawn upward when the cervix begins to dilate. Tumors which are adherent in the cul-de-sac or cervical myomas will not allow delivery per vagina; while tumors on the anterior wall will seldom obstruct either the descent of the presenting part or the pelvic outlet. The submucous type of growth when located near the inlet is responsible for the faulty adaptation of the presenting part. This gives rise to malposition and presentation. A series reported by Lynch shows the incidence of transverse as 18 per cent and breech 22 per cent, as compared with the usual incidence of 2 and 3 per cent, respectively. The number of such cases requiring operative interference will be greatly increased—a higher maternal and fetal morbidity and mortality will be the result.

Uterine inertia is undoubtedly the most common cause of dystocia in the pregnant woman with fibromyomas. The interstitial growths replace the normal musculature, and weak inefficient contractions result. The first stage of labor will be either greatly prolonged or not completed, and maternal exhaustion and fetal distress will ensue, making the termination of both the first and second stages a major obstetrical procedure. In the third stage of labor, uterine inertia may also produce complications. If the tumor involves the area of placentation, an abnormal decidua may be present, causing difficulty in the mechanism of separation. Adherent placenta will require more manual removals, and with the inertia alarming hemorrhages will frequently result.

Treatment.—Routine management of the complications described above cannot be outlined. The treatment must be individualized. A few suggestions may be of value in the management of these cases, keeping in mind, however, that the size, location, number of tumors, period of gestation, and conditions present at the onset of labor will determine the course that is most advisable to pursue. During the latter months some authors recommend the daily use of the knee-chest position. While this may be of value in so far as relieving the symptoms of pelvic pressure, its value in displacing tumors in a pelvic location is open to question.

The presence of fibroids in pregnancy is not an indication for induction of labor. Prior to the onset of the contractions of labor, patients frequently have irregular pains, which has been described as the preparatory stage of labor. This change may be of some value in pulling the tumor out of the pelvis so that the presenting part may enter. It seems advisable, therefore, to allow labor to come on naturally in order to take advantage of what nature can do.

After the onset of labor, when obstruction of the birth canal is seen to exist, cesarean section is indicated. Patients should not be allowed to labor against this obstacle, for rupture of the uterus may occur. Simple excision of the tumor or removal of the uterus will depend on the size, the location, and type of fibroid encountered.

The most difficult complication to treat in this condition is uterine inertia. Analgesia given too early in labor will increase the tendency toward inefficient uterine contractions. Rest periods have been advocated when the patient shows fatigue, but are usually not indicated until progress is at a standstill. Uterine inertia, if persistent, will require operative interference, and too great delay will add materially to the obstetrical risk when interference becomes imperative.

The third stage should always be treated conservatively, and this should be reëmphasized when one is dealing with inertia or fibroids involving the placental site. Allow the placenta to separate normally and interfere only for the indication of bleeding. The oxytocic drugs should not be used until separation has taken place.

To summarize the effect of fibromyomas on labor it may be said that:

1. Uterine inertia is the most difficult complication to treat and by far the greatest danger.

2. The incidence of tumors which will actually obstruct delivery is small when labor is allowed to ensue.

3. While fibroids may be considered a real complication in labor, the prognosis for a satisfactory end-result is good when the condition is diagnosed and the treatment individualized.

* * *

III. CERVICAL FIBROMYOMATA

Donald A. Dallas, M.D. (490 Post Street, San Francisco).—Cervical fibromyomata are discussed separately here for the reason that they present a somewhat different problem from those occurring in the body of the uterus. They occur much less frequently than the fundal tumors, the

incidence being variously estimated at from 1 to 8 per cent of all uterine fibroids. They are said to be always single tumors as contrasted with those in the fundus, which are frequently multiple. They vary in size from small nodules to large masses, entirely filling the pelvis and weighing up to 7,000 grams. They arise in either the anterior or posterior wall of the cervix—more often in the posterior. As they increase in size they can remain in the wall of the cervix, or can grow in any direction. If the growth is toward the canal of the cervix they frequently become pedunculated and protrude through the external os into the vagina. If the growth is outward they slowly displace the tissues about the cervix in the direction of least resistance, and may ultimately fill the pelvis almost completely. In consequence of being fixed deep in the pelvis by the supporting tissues of the cervix, their growth, if great enough, will displace and compress the ureters, the bladder, the urethra, the sigmoid, and the rectum. The cervix, when these tumors are of the larger type, is usually displaced forward under the symphysis and frequently cannot be exposed for inspection, and occasionally cannot be reached by the examining finger. When the growth is very large, it may protrude through the external os and fill the vagina. Cases have been reported in which the tumor actually spread the vulva and extended beyond it for several centimeters. The cervix in these cases may be dilated as much as during the delivery of a full-term baby. Frequently the fundus of the uterus also contains fibroids, but if free from them it may be "perched on the top of the cervical fibroid like a cap." A number of cases of cervical fibromyoma have been reported which have developed after supravaginal hysterectomy.

Cervical fibromyomata are apparently not as much under the influence of the sex hormones as those located in the body of the uterus, and consequently are more likely to continue to grow after the menopause. It is also interesting to note that they do not respond well to radiation therapy. These tumors have a tendency to become densely adherent to the surrounding organs, especially the urinary bladder and rectum, and this characteristic makes their surgical removal much more difficult.

One of the common symptoms produced by these tumors is profuse hemorrhage. The patients are frequently markedly anemic, and transfusion either before or after operation is often necessary. Pressure symptoms are also common; pain, marked frequency and incontinence of urine due to compression of the bladder, ureters and urethra, and constipation due to pressure on the rectum, are the most usual ones. The engagement of the presenting part during labor is often interfered with by a cervical fibromyoma. About one-half of the cases reported in the literature have been discovered at this time. In these cases the presenting part remains very high and is often deflected toward one or the other iliac fossa. When this occurs in spite of adequate pains, one should always suspect the presence of a cervical fibroid.

The treatment of cervical fibromyomata is always surgical. The pedunculated submucous fibroids which protrude through the external os into the vagina can, as a rule, be removed without difficulty. The pedicle can be ligated, cauterized or clamped. If the pedicle is thick and hemorrhage is feared, the clamp may be left in place for forty-eight hours, when it can be removed without danger of bleeding. These tumors, whether arising from the cervix or from the body of the uterus, are always infected, frequently with streptococci. In cases where abdominal hysterectomy is necessary, it is much wiser to remove the tumor as described and wait about three weeks before doing the abdominal operation.

The treatment of cervical fibroids which interfere with the presenting part during labor varies with the size and location of the tumor. As cesarean section is usually necessary to deliver the child, the tumor can be removed after the placenta has been extracted. This can be accomplished by making an incision through the endometrium over the tumor and shelling it out as in the ordinary myomectomy. If this does not seem feasible, hysterectomy is probably indicated.

The surgical removal of the smaller cervical fibromyomata is not particularly difficult and is attended only by the usual operative risk and, as a rule, complete hysterectomy is the operation of choice. The removal of the larger tumors presents great technical difficulties and carries with it a high mortality. As has been stated before, these large tumors displace and compress to a greater or lesser degree the ureters, bladder, sigmoid, and rectum. Any of these organs may be densely adherent to the growth and may be displaced to a remarkable extent. One surgeon reported that, on incising the peritoneum over the top of a large cervical fibroid, he found that he had incised the bladder. The ureters should always be carefully looked for and identified, for they may be found on top of, beside or below the tumor. The uterine arteries are also located only with difficulty, and it is important that they be found and ligated early in the operation in order to prevent excessive hemorrhage. The bladder and rectum should be freed from the tumor by careful dissection. It is much wiser to leave a part of the tumor attached to the wall of the bowel or bladder than to open either of these organs in attempting to free them. In some of the more difficult cases bisection of the uterus and tumor can be done. This will frequently give the operator more room in which to work and allow him to ligate the uterine artery on one side. He can then free the tumor from below upward, with little bleeding and much less danger of injury to the ureter, bladder, or rectum. The same procedure can then be carried out on the other side and the operation completed in the usual manner.

In conclusion, I should like to emphasize that the treatment of cervical fibromyomata is always surgical; that the removal of the smaller tumors is not difficult if one knows in advance that the tumor originated in the cervix and remembers that the ureters, uterine arteries, bladder, etc., are probably displaced by the tumor. I should also like to stress the fact that the excision of the larger tumors is likely to be exceedingly difficult and suggest that the most expert help available be secured before attempting the operation.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

HOWARD MORROW.....President
WILLIAM W. ROBLEE.....President-Elect
LOWELL S. GOIN.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

OFFICIAL BUSINESS

DIGEST OF EXECUTIVE COMMITTEE MINUTES

Committee met in San Francisco on April 2, 1938. Creation of Institution Committees through action of Board of Supervisors was recommended.

Proposed plan for medical and hospital care submitted by Standard Oil Company employees was referred for investigation and report to Public Relations Committee.

A conference of representatives of county societies concerned with medical care of indigent itinerants was approved.

Invitation extended to American College of Physicians to hold its 1939 convocation in San Francisco.

Pneumonia control program referred to Committee on Public Health.

Discussion on malpractice insurance and statement for publication approved.

San Francisco Employees Medical Plan referred to Committee on Public Relations.

Time was fixed for hearing appeal from action of San Diego County Society.

Routine matters acted upon. F. W.

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Postgraduate Conferences.*
2. *A Challenge to Medicine.*
3. *Resolutions Establishing Principles of Ethics and Conduct.*
4. *Passing Comment.*
5. *American Medical Association San Francisco Session.*
6. *A Minimum Program for County Societies.*
7. *Association Nights.*
8. *Wanted.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Hospital Rates.*
2. *Health Education.*
3. *You Will Be Interested.*
4. *Malpractice.*

POSTGRADUATE CONFERENCES

The following represent the places and the subjects presented in a series of postgraduate conferences:

RIVERSIDE COUNTY MEDICAL ASSOCIATION

Postgraduate Conference, February 14, 1938, at Sherman Institute, Riverside

PROGRAM

4:00 p.m.—Nonacute Types of Arthritis (clinical demonstration), John Dunlop, Pasadena.

5:00 p.m.—Laboratory Examinations, John F. Kessel, Los Angeles.

6:15 p.m.—Dinner, Sherman Institute.

7:15 p.m.—Menstrual Disorders, Henry N. Shaw, Los Angeles.

8:15 p.m.—Surgical Treatment of Pulmonary Disease (clinical demonstration), Frank S. Dolley, Los Angeles.

* * *

SANTA BARBARA COUNTY MEDICAL SOCIETY

Postgraduate Conference, March 12 and 13, 1938, at Santa Barbara Clinic, Santa Barbara

PROGRAM

Saturday

9:00 a.m.—Clinico-Pathological Conference, Clark E. Brown, Santa Barbara.

10:00 a.m.—Cardiovascular Disturbances, Frank Nuzum, Santa Barbara.
Surgery of Acute Abdomen, W. W. Washburn and George W. Pierce, San Francisco.

11:00 a.m.—Dermatology, Samuel Ayers, Los Angeles.
Gynecology and Obstetrics (sterility, artificial insemination), Erle Henriksen, Los Angeles.

Luncheon

2:00 p.m.—Endocrinology, E. Kost Shelton, Los Angeles.

3:00 p.m.—Pneumonia: Serum Therapy, Roy Thomas, Los Angeles.
Eye Injuries, J. N. Osburn, Los Angeles.
Nasal Hemorrhage (malignancies of nose and throat), Simon Jesberg, Los Angeles.
Gynecology and Obstetrics (cesarean section, specific infections, vomiting of pregnancy), John Vruwink, Los Angeles.

Dinner

Evening—Allergy, Albert Rowe, San Francisco.

Sunday

10:00 a.m.—Bleeding Ulcer, William Boeck, Los Angeles.
Allergy in Children, Albert Rowe, San Francisco.
Drugs and Therapeutics, Chauncey Leake, San Francisco.
Endocrinology (migraine, obesity, undescended testicle), E. Kost Shelton, Los Angeles.

11:00 a.m.—Head Injuries, Howard Naffziger, San Francisco.

Luncheon

2:00 p.m.—Orthopedics (foot and knee injuries, low-back pain), John Wilson, Los Angeles.
Burns, W. W. Washburn and George W. Pierce, San Francisco.
Pneumonia in Children, Earl Moody, Los Angeles.

Afternoon—Eye, Ear, Nose and Throat Symposium, Simon Jesberg, J. McKenzie Brown and J. N. Osburn, Los Angeles.

* * *

ORANGE COUNTY MEDICAL ASSOCIATION

Postgraduate Conference, March 15, 1938, at Santa Ana

PROGRAM

No. 13—Disturbances of the Peripheral Circulation, Howard West, Los Angeles.

No. 24—Appendicitis, Charles E. Phillips, Los Angeles.

No. 90—Proctology Treatment, W. H. Daniel, Los Angeles.

No. 29—Tumors of the Abdominal Cavity, Eric Larson, Los Angeles.

No. 36—The Principles of Treatment of Compound Fractures, Paul E. McMaster, Los Angeles.

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

IMPERIAL COUNTY MEDICAL ASSOCIATION

Postgraduate Conference, March 15, 1938, at Imperial County Hospital, El Centro

PROGRAM

No. 28—Peritonitis, Henry Bonesteel, Los Angeles.
No. 57—Abdominal Pains in Children, J. Norton Nichols, Los Angeles.
No. 38—Menstrual Disturbances, Erle Henricksen, Los Angeles.
No. 45—Postpuerpural Complications, William B. Thompson, Los Angeles.
No. 63—Endocrinology in Children, Ezra Fish, Beverly Hills.

* * *

SAN BERNARDINO COUNTY MEDICAL ASSOCIATION

Postgraduate Conference, April 7, 1938, at Elks Club, San Bernardino

PROGRAM

No. 10—The Decompensated Heart, Robert W. Langley, Los Angeles.
No. 37—Traumatic Surgery, Robert W. Wilcox, Long Beach.
No. 30—Colitis, Frank W. Otto, Los Angeles.
No. 34—Malignancy, Orville Meland, Los Angeles.

* * *

The following appraisal may be quoted as a quite representative expression of opinion expressed by those in attendance:

Bakersfield, March 18, 1938.

To the Secretary:—The conference at Santa Barbara was, I think, a very monumental success, especially considering the fact that it was the first. There were 110 registrations.

Unfortunately, some very disagreeable weather blew in from the north, almost repeating the flood situation of the week before, and the rain in Santa Barbara was very heavy. Ten from Kern braved the weather, having to drive almost into Los Angeles and then back north, not knowing when they could get out of Santa Barbara if the rain continued. San Luis Obispo County was exceptionally well represented. The attendance from Ventura was very disappointing. The program was exceptionally good.

The eye, ear, nose and throat symposium was, I think, exceptionally successful, it remaining in constant session Sunday for about three hours. The Saturday night dinner and dance at the Montecito Country Club was a very enjoyable affair and taxed the capacity of the club. The attendance at both the sessions and the Saturday night dinner were considerably greater than anticipated. Doctor Rowe gave a very excellent talk after the dinner, which he made snappy and to the point and did not drag it out, as often happens at these affairs.

I tried to get the reaction to the conference by different groups of men, and it seemed to be unanimous that it was very fine. At the end of the last general session on Sunday I asked for the pleasure of the group whether or not they wished the conference repeated. There was not a dissenting vote. Some of the men were so enthusiastic that they wished to have it repeated this fall. One thing that impressed me quite strongly, which I heard repeatedly, was that the men were very pleased to meet and become acquainted with the fellows from the adjoining societies.

The wives were entertained by the Auxiliary of Santa Barbara County, and I think they are as enthusiastic about the conference as are the men.

With the first conference now out of the way, I am under the impression that the district should have a permanent postgraduate organization of one or two men from each county and I shall attempt to have that done during the Pasadena meeting.

Taking everything into consideration, I do not see how we could have improved our first effort, and a great deal of credit is due Doctors Henderson and Stone and others who worked with them for the way it was handled.

I believe the next one will see the out-of-town registrations at least doubled.

Sincerely yours,
LOUIS A. PACKARD, M.D.

* * *

March 19, 1938.

To the Secretary:—At your request of March 16 I am herewith giving you reports of the Riverside and Santa Ana conferences.

The Riverside Postgraduate meeting was held on the 14th of February at the Sherman Institute. It was well attended, there being in the neighborhood of one hundred men present. I did not arrive in time to hear the lecture on nonacute types of arthritis and laboratory findings, but all seemed to be well pleased with them. Shaw and Dolley were especially good with their subjects. There was more interest and better attendance than at Riverside a year ago. Clinical material, x-rays, and charts were seen in abundance.

Orange County held its Postgraduate meeting last Tuesday, March 15, at the Ebell Club in Santa Ana. An attendance equal to that of Riverside was present. West, on peripheral circulation, gave an excellent presentation with two clinical cases before him. Phillips' talk was good. Daniels gave an excellent talk on proctology, meeting the general practitioner in so many of the common ills that present themselves to the office. No charts or clinical material was used, but it was a valuable presentation. Larson, on abdominal tumors, was one of the high lights of the meeting.

Very truly yours,
CALVERT L. EMMONS, M.D.

* * *

Holtville, Calif., March 23, 1938.

To the Secretary:—The Imperial County Medical Society's regular meeting was held in the Imperial County Hospital, Tuesday, March 15, at 3 p. m. The meeting was called to order by Dr. H. B. Graeser, president. The following members were present: W. W. Apple, M. A. Barmore, T. C. Bartholomew, F. A. Burger, M. C. Canfield, F. C. Gregg, H. I. Gregg, P. Hodgkin, K. H. Kortheuer, J. L. Parker, F. G. ReBell, and Doctor Hawkenson.

Doctor Barmore, who was in charge of the Postgraduate Clinic, presented the speakers. Owing to a scarcity of cases, the clinic was necessarily didactic. Doctor Collins reviewed the field of peritonitis, giving the generally accepted methods of diagnosis and treatment.

Doctor Henriksen, in discussing menstrual disorders, called particular attention to the lack of uniformity of the results obtained in treating these conditions with endocrine products. Dr. W. Benbow Thompson spoke on postpuerpural complications. He gave a complete account of conditions encountered at this stage and ably discussed their treatment. Dr. J. Norton Nichols spoke on abdominal pains in children, stressing surgical aspects.

A round table discussion was held after each clinic. Dinner was served at the hospital between 6:00 and 7:00, and the clinic was concluded at 9:30 p. m. It was moved and seconded that a vote of thanks be sent to the Postgraduate Committee in obtaining men of such high quality for our Postgraduate Clinic. It was the unanimous opinion of those present that we should have at least one more clinic before the summer season starts.

Sincerely yours,
WILLIAM A. CLARKE, Secretary.

A CHALLENGE TO MEDICINE

Dr. R. G. Leland of the American Medical Association Bureau of Economics, recently commented upon social changes under the title at the head of this item. It is felt that the following extracts will interest members and furnish items for thought:

"Thus far the medical profession in the United States has averted the entanglements, political domination and inevitable deterioration of medical service that would come from a system of compulsory sickness insurance.

"The persistent propaganda of the proponents of socialized medical service has caused many physicians to doubt the future of medicine. A few are even exhibiting a fatalistic attitude in declaring that the socialization of medicine is inevitable.

"The socialization of medicine, as the term is commonly used, refers to any form of medical advice, diagnosis and treatment provided, conducted, controlled or subsidized by the federal or any state government, with the exceptions stated.

"No value can be derived from criticism of a country for having adopted a system of state-managed medicine, but a critical analysis of the systems themselves may be helpful in determining whether such methods are preferable to the free and independent practice of medicine such as exists in the United States.

"A careful examination of the systems of state-managed medicine reveals the following conditions:

"1. There is no decrease in the cost of medical care. Instead, the system adds a staggering cost of administration.

"2. Public health and preventive medicine are not assisted or advanced. State-managed medicine does not provide the annual health examinations or the immunizations usually promised before the system was adopted.

"3. Morbidity and mortality are not reduced.

"4. The problem of so-called catastrophic diseases is not solved.

"5. Neuroses are created.

"6. Overmedication is encouraged.

"7. The burden of the system is distributed over the low-income class, which is least able to bear it.

"8. Medical care for the indigent is omitted.

"9. The medical profession is divided into a 'first' and 'second' class.

"10. Graduate education is not encouraged and is usually neglected.

"11. The hospital load is increased. Hospitals are encouraged to practice medicine.

"12. Attention and financing are concentrated on the less essential health and medical measures.

"13. Diagnosis and treatment are mechanical and superficial.

"14. Professional associations are compelled to devote their energies to the defense of medicine against nonmedical and political interference rather than to scientific and educational activities.

"15. Medical service becomes a political issue.

"16. Control over medical service is placed in the hands of unqualified, nonmedical individuals and organizations.

"17. The road is closed to the use of more desirable methods.

"They have observed that sickness insurance has constantly restricted the direct relations between patients and physicians in private practice. Formerly there was a human relation which depended on confidence in the physician. Between the patient and his physician there is now a third party—the insurance carrier, and a fourth party—the government, a supervising bureaucracy which compels the physician to follow its regulations. Furthermore, these observers assert that if treatment does not bring the expected result, the physician is discredited and is made punishable for every unavoidable failure.

"Reports from countries having state-managed medicine state that the insured have not been satisfied with the new system. Restrictions of the means of healing have been offensive to them; they have looked on the contributions to the sickness insurance system, taken from them through their employers by compulsion, as a retained share of their wages. They knew that they could obtain this retained money only in the form of insurance medical service or cash benefits. They believed they had been compelled to pay out money without receiving an equivalent. The only way in which the money or an equivalent could be recovered was to declare themselves sick and to meet the conditions set down by the law. This was an easy matter.

"Even in Europe some physicians have expressed the view that the idea of a free medical profession must not be abandoned; once it is completely abolished a cultural value will have been lost that cannot be replaced or restored. To physicians, human values are of greater importance than are political expedients.

"Even at its best, do the American people and the American physicians want such a system? Before we wholly destroy our present plan of medical practice through revolutionary legislation, let us inquire carefully into the value of what we have, and study searchingly the proposals of those who would take it from us, lest worse come in its place.

"The proponents and agitators for some radical change in the method of distributing medical services have made some serious and startling charges concerning the methods now in use. They continue to assert that 50 per cent of the population receives no medical care. A survey of some 38,600 persons made by the Committee on the Costs of Medical Care showed that 47.1 per cent had no illness over a period of more than a year. The study also showed that 47.9 per cent of these persons had the services of physicians. Only 5 per cent of the persons involved in the survey were presumably in need of medical services, but for some reason did not avail themselves of medical care. Perhaps 5 per cent is not too large an estimate of those who because of human characteristics manifested as ignorance, stupidity or prejudice prefer cultism, patent medicine, the advice of friends or relatives or no medical service at all.

"The medical profession today is conducting more social experiments in the methods of distributing medical services than all of the proponents for change have ever conducted. Out of the two hundred or more projects that are being studied or operated by county or state medical societies, it is hoped that methods may be found that can be utilized to supplement existing medical facilities wherever necessity demands.

"These meddlers with medical practice assert that present methods in the United States are costly and inefficient. In countries having state-managed medicine, there are as many bureaucratic employees as there are physicians giving medical service. State-managed medicine imposes such extensive red tape, record keeping and political interference, dominance and control on the physicians practicing under the system that they cannot devote the time they should to the actual practice of medicine. Loading the system with unnecessary bureaucratic personnel and with political meddling and direction tend to increase the cost of medical service and at the same time to reduce its quality.

"To combat the agitation for drastic changes in medicine, the medical profession must continue to practice good medicine. It has been accused of being individualistic. This criticism should be accepted as a compliment insofar as the diagnosis, treatment and close personal confidential relations of private practice are concerned. Physicians must continue to be individualistic and ethical in their private ministrations to maintan health and to alleviate sickness. But they must speak and act collectively on matters pertaining to economics, public relations, legislation, the preservation of professional ideals and traditions, and the maintenance and advancement of medical ethics and the standards of medical education and practice.

"The large and representative group of ethical physicians have an obligation to unite solidly in sentiment and in action against the utterly false representations of the reactionary, radical, self-styled experts who would destroy medical values that have required generations and centuries of accumulated scientific effort and experience to acquire.

"Shall medicine continue to be practiced by men and women who are scientifically trained and who are devoted to the relief of suffering humanity, or shall the practice of medicine be taken over by a group of medically untrained bureaucrats who will use the medical profession as a tool and the sick as clay in moulding a huge political machine?

"When physicians become, if they ever should, mere robots, making diagnoses from card indexes and mechanical gadgets and prescribing treatment from prepared and numbered labels, and when patients become a mere collection of interesting human parts to be shunted from one corner to another of a medical repair shop for some heartless and pseudoscientific tinkering, America will have lost one of its greatest institutions—free and independent medicine—and the American people will have lost some of their most valuable human traits, namely, confidence in, respect for, and reliance on the scientific men and women who protect their health and prolong their lives."

The last quotation might well be printed in large type and hung in every doctor's reception room and in the waiting rooms of every hospital.

RESOLUTIONS ESTABLISHING PRINCIPLES OF ETHICS AND CONDUCT

Certain county societies have sought to amplify the Principles of Medical Ethics by adopting, through resolutions, additional rules governing professional conduct. The question has been raised as to the correctness of such a procedure and also whether such rules and regulations can be applied to members. Another question raised is whether disciplinary action against a member for violation of such rules could be sustained.

An opinion was sought from the Judicial Council of the American Medical Association, the highest authority in our federacy. The following opinion has been received:

(COPY)

AMERICAN MEDICAL ASSOCIATION
JUDICIAL COUNCIL

March 19, 1938.

Dear Doctor Warnshuis:

Your letter of March 1 to Doctor West, requesting a ruling or advice concerning basing charges agalnst a member on a resolution adopted by the society, has been sent to me for reply. It appears that there is a particular practice which several of your societies desire to terminate by disciplinary action, viz., entering into contracts and agreements with certain insurance companies to render professional services for fees that are anywhere from 25 to 50 per cent lower than the regular state compensation fee schedule or the fees customary in their respective vicinities.

This is a particular condition which the society desires to remedy by a definite pronouncement, and it is similar to the rules of conduct which a few of the California societies have adopted and have used as a means of disciplining their members, as, for instance, in the Kern County Medical Society. This adoption of rules of conduct has received official disapproval of the Judicial Council in a recent annual report in which the statement was made, if I remember correctly, that all of these rules of conduct covered points on which disciplinary action might be taken successfully under the Principles of Ethics without the adoption of any special rule of conduct. In this particular instance cited by you, it seems to me that the Principles of Medical Ethics cover the situation adequately. There is a section on contract practice which would appear to make that action unethical. There is also the section declaring

it to be unethical for a physician to dispose of his services to a lay body under any terms or circumstances by which a direct profit from the fees or salaries paid accrues to the lay body. It would seem that this section also might apply. I regret that I do not have at hand a copy of the Principles of Medical Ethics to which I can refer, but I am quite sure that some of the general principles of ethics covered in the early sections of the publication could also be evoked.

May I offer you the following argument: The disciplining of a member under a resolution which requires only a majority vote of those present when the resolution is presented is inconsistent with good law and procedure. To judge and discipline one member under a resolution which can be adopted or rescinded at any time by a majority of those present at a meeting and another member by a process much more representative of the whole membership is not good law. I am inclined to think that because the loss of membership in a local society also means loss of membership in a state and national organization, no disciplinary action involving membership should be taken which is not based on violation of the Constitution or By-Laws or else violation of the American Medical Association's Principles of Medical Ethics.

Sincerely yours,

GEORGE EDWARD FOLLANSBEE,
Chairman, Judicial Council.

The attention of county society officers is particularly directed to the last paragraph of this letter.

County societies should promptly initiate suitable action to include their special rules and regulations in their by-laws under that section that governs the conduct of members. This is important, and action in this matter must not be delayed. Introduce such an amendment at your next meeting.

PASSING COMMENT

The following item evidences anew how members are willing to serve their communities.

It may be that there are some folks living in this county who need medical advice or attention, and who feel that they cannot afford to pay for the service.

In order that such people may have the services they need, Dr. William Sullivan, who is located in Mariposa, will set aside Thursday afternoon of each week for receiving all such persons and he will be pleased to give them advice and medical aid without charge.

Doctor Sullivan has had much experience in this kind of work and he asks all those who wish this free service to call at his office on Thursday afternoons.

* * *

American Medical Association, San Francisco, June 13-17: An opportunity you can ill afford to overlook. Be sure you bring your 1938 Fellowship card.

You can make Fellowship application at the Registration Bureau in the Civic Auditorium.

* * *

Minutes of the Pasadena annual session will appear in the July issue.

* * *

Since 1847 over three thousand surveys have been made by a variety of organizations looking into the practice of medicine and the distribution of medical care. Soon there will be indicated a survey of surveys. It is about time to declare a closed season on surveys that are becoming a popular pastime and in some instances something worse.

* * *

There are some three hundred medical societies in this country in addition to the component units of the American Medical Association. President Abel observes that "the utility of many is negligible or questionable." One's first loyalty should, yes, must be, to his county and state medical societies.

* * *

Don't write *direct* to San Francisco hotels for American Medical Association reservations. No matter what influence you may have, *no* hotel will assign you a room. *All* reservations must be made through the American Medical Association Hotel Committee, Room 2004, 450 Sutter Street. Don't pack a grouch if your favorite hotel is booked to capacity and you are assigned somewhere else. Over 2,500 rooms are booked, but plenty first-class rooms continue to be available and you will be comfortable even if not located on Nob Hill or around Union Square.

* * *

It is easy to cite generalities and to quote foreign percentages and ask why the same percentages cannot be recorded in this country. We hear frequently about low infant and maternal mortality in Norway and Sweden. They are low in these countries, but the conditions that prevail can never be instituted here. For instance, practically every parturient woman is attended by a midwife. These midwives have had three years of hospital training, pass rigid examinations, and are required to attend postgraduate classes each year. In Stockholm 98 per cent of all births take place in maternity hospitals. None in general hospitals. In normal cases the women are attended by persons who have no part in the care of medical or surgical patients. Try to establish these two principles in this country!

* * *

To be a continuous student—that is the obligation of every member engaged in practice. He must acquire and reflect an inquisitive, wisdom-seeking attitude and viewpoint. Through personal effort, planned readings, the devotion of time to postgraduate work and attendance at medical meetings, local, state, and national—by these means the physician must remain abreast of scientific progress and keep out of the rut of habit and routine. There is no place in medicine for the indifferent doctor; he must be a continuous student.

AMERICAN MEDICAL ASSOCIATION SAN FRANCISCO SESSION

The week of June 12 will witness the assembling of some ten thousand physicians and surgeons in San Francisco for the annual session of the American Medical Association. Many of them will be accompanied by members of their families. Several eastern states members have arranged to come by special trains that will stop at scenic points en route, not a few will travel by automobile, and some will come by plane. For a goodly number it will be their first visit to the Pacific Coast and the Golden Bear State.

San Francisco's medical fraternity has been engaged for months, under the leadership of Howard Morrow, General Chairman of the Local Committee on Arrangements, in perfecting details for the session and providing for the pleasure and comforts of its guests.

All the sessions will be held in the buildings surrounding the Civic Center. To provide needed accommodations for the commercial and scientific exhibits, general scientific sessions, general meeting, and section meetings, the following buildings will be utilized: Auditorium, Opera House, Veterans' Building, and the Empire Hotel auditoriums. The House of Delegates will convene in the Sir Francis Drake Hotel, which has been reserved completely for delegates, councils, bureaus, and the official family.

The official program will appear in a special San Francisco number of the *Journal of the American Medical Association* that will be issued in May.

* * *

Members should carefully read that issue, as it is impossible to reprint the extended program and announcements for this national gathering.

* * *

A FEW HIGHLIGHTS

1. Monday, June 13, opening of exhibits and registration in the Civic Auditorium.

2. Monday and Tuesday, June 13 and 14, general scientific sessions in the Opera House, morning and afternoons. Thirty-minute talks by distinguished clinicians.

3. Tuesday evening, June 14, opening of general meeting in the Opera House. President's annual address. A formal outstanding function and occasion.

4. Wednesday, Thursday and Friday, morning and afternoon sessions of sixteen scientific sections.

5. Thursday evening, Palace Hotel, president's reception and ball. A magnificent social function.

6. The Woman's Auxiliary, Fairmont Hotel, Monday to Thursday—meetings, luncheons, dinners, receptions.

7. Entertainment: Fraternity and alumni banquets, dinners, scenic trips, boat ride on the Bay, House of Delegates dinner, officers' dinner. Many private dinners and social functions.

* * *

With a welcome and cordiality, in degree exemplified alone by the profession of San Francisco and California, the visitors will find themselves among hosts who will provide for their every comfort and enjoyment. Departing, they will carry with them memories of happy hours and a profitable annual session.

* * *

TO CALIFORNIA MEMBERS

To our California members the advice is given that all who possibly can should not fail to attend this national meeting. It is the greatest postgraduate opportunity in the world. Nowhere else in the world can one find a five-day session that enables a practitioner of medicine to embrace opportunities for educational betterment such as are provided in the sectional and general programs and the scientific and commercial exhibits. He who fails to attend this American Medical Association San Francisco session neglects a golden opportunity.

It is hoped that not less than three thousand California Fellows will register and attend. Do not forget to bring your Fellowship card—and also *you must be a Fellow* to register and gain admission.

* * *

PRESESSION MEETINGS

Commencing on Wednesday, June 8, and extending through Sunday, June 12, there will be presession meetings of allied national medical organizations in San Francisco. The following is a partial list: American Dermatological Association; American Psychiatric Association; American Ophthalmological Association; Academy of Tuberculosis Physicians; American Proctological Association; Society for Study of Rheumatism; Society for Study of Allergy; American Society of Clinical Pathologists; American Pediatric Association; and others.

A MINIMUM PROGRAM FOR COUNTY SOCIETIES

County societies must be maintained as going, active units of our Association, a hit-and-miss policy and indefinite, disassociated activities, are not productive for the greatest good. To achieve results, to attain objectives, and to enlist and hold the interest of members, every county society should place into operation a minimum program of work.

To that end this minimum program is outlined for consideration.

Section 1. Scientific.

(*a*) Ten meetings to be held each year. Local speakers are to appear before six meetings with definite planned papers or case presentations. Four guest speakers.

(*b*) A program of physical examination in which all members shall agree to have a complete physical examination yearly.

(*c*) The establishment of a "Health Hour" in each member's office once or twice a week before or after regular office hours. The Society to sponsor publicity to acquaint the public with the fact that during these hours persons unable to pay regular fees will be given tests and immunization treatment for a reduced fee. This fee to be determined by the county society.

(*d*) Each society to form one or more teams, composed of two or three members, who will prepare a program and present it on request before an adjacent county society.

Section 2. Public Education and Information.

Each society shall sponsor or cause to be sponsored at least five public lectures during the year for: each high school; Parent-Teacher organizations; luncheon clubs; women's clubs; public at large.

Section 3. Social Functions.

Each society shall hold at least three dinner meetings to be addressed by educators, business men, attorney or civic official; one annual banquet; one annual picnic; joint dinner with dentists, attorneys, pharmacists, and hospital officials.

Section 4. Publicity.

Each meeting and activity shall be reported to local newspapers in such form that at least one important fact of interest and value to the public is imparted.

If county societies will adopt this minimum program it is predicted that members will reveal interest and attend. This program is not a self-starter—someone has to assume the initiative. Will you be that someone in your county?

ASSOCIATION NIGHTS

On March 14 President Morrow, Secretary Warnshuis and Councilor Alfred Phillips were in attendance at the Rio Del Mar Club in Aptos at an Association night for Santa Cruz, Monterey, and San Benito county medical societies. Some eighty-five members were present at the dinner and the talks and discussions that continued till 12:15 a. m.

These three societies are active and progressive, and represent the large majority of eligible doctors in these counties.

On March 17 President Morrow, Secretary Warnshuis, and Legal Counsel Hartley Peart attended the seventieth annual banquet meeting of the Sacramento Society for Medical Improvement, our oldest county medical society.

Speaker Lowell S. Goin of Los Angeles, was the guest speaker. Past President Robert A. Peers was also an honor guest. This annual banquet is always an enjoyable function, characterized by friendship and a program of music and local skits in addition to the main address of the evening. Speaker Goin rose to the occasion and gave a very entertaining address. It was a delightful evening in the company of the members of this very active county unit.

WANTED

It is believed that a number of members have in their possession teaching movie medical films. Several of our outlying county societies that have difficulty in obtaining guest speakers are desirous of securing teaching films for their meetings.

The "wanted" request is made that members having such films will kindly advise the State Secretary, and advise as to subject, content, length of run, and whether they may be borrowed for county society use.

Your response and assistance in making such films available for county societies is earnestly requested.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Hospital Rates

The Association of California Hospitals at its recent annual session adopted the following resolution:

* * *

(COPY)

ASSOCIATION OF CALIFORNIA HOSPITALS

Resolution re Contract Rates

WHEREAS, The hospitals of California are constantly striving to balance budgets, and more often than not fail to balance their budgets; and

WHEREAS, True cost studies show many published rates, particularly ward rates, less than cost; and

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

WHEREAS, Insurance companies, corporations with medical departments, and physicians doing group practice have asked or demanded special rates and in many cases succeeded in getting them; and

WHEREAS, These rates are not founded on any social basis, but are preferential to those most able to pay full costs; and

WHEREAS, Such policy of granting special rates to powerful companies has been thoroughly discredited and branded as bad business ethics; and

WHEREAS, Such policy not only is bad for hospitals, but also results in unfair competition in the profession of medicine also; therefore be it

Resolved, (a) That hospitals in this Association go on record as disapproving the practice of entering into special contracts at special rates;

(b) That hospitals in this Association recommend and urge all hospitals to grant no rates below their own published schedule, except to individual cases of merit, and to those cases after social service investigation proves such right;

(c) That a copy of this resolution be forwarded to the California Medical Association and to its members, assuring each high class practicing physician that secret agreements will place him at a disadvantage.

The resolution is commended. In this connection it is not amiss to remind members that contracting or agreeing to render professional services to insurance companies, corporations, or contractors at reduced fees is a violation of the Principles of Ethics and the policies of the American Medical and California Medical Associations. Violation of these rules by members renders them liable to disciplinary procedures.

County societies do well when they remain alert and exercise their authority in causing observation and compliance with adopted principles.

Health Education

During the past five months two series of public talks have been given in San Francisco through arrangements perfected by the Department of Public Relations. One was a series of eight talks given at a general assembly of the Girls High School in San Francisco. The second was a series of seven talks before the evening assembly of the San Francisco Y. W. C. A. A lecturer was also provided for the Woman's Club of Vallejo.

The following letter of appreciation has been received:

SAN FRANCISCO PUBLIC SCHOOLS

San Francisco, Calif., March 24, 1938.

California Medical Association
450 Sutter Street,
San Francisco, California
Attention: Dr. F. C. Warnshuis, Secretary.

On behalf of the Medical Club of Girls High School, I wish to thank you for your kindness in sending speakers to this Club.

The members of the Medical Club have enjoyed the very interesting talks the speakers have given, and I have written them letters expressing our appreciation and thanks.

We hope that you will be kind enough to continue sending us speakers.

I thank you.

Sincerely,

HAZEL SPENCER, Secretary.

County societies should sponsor such meetings. They accomplish the gaining of public good will for the profession and enlighten the public upon health questions enabling the people to detect the false claims and advice of the quack and manufacturers of drugs. Plan such meetings for your county.

You Will Be Interested

Every member should be interested and read that section of the *Journal of the American Medical Association* devoted to "Organization." In each issue, just before the back advertising section, you will find much information and comment upon legislation, economics, federal activities, and organizational activities.

It is a weekly digest and comment upon what is transpiring in the realms of government, social security, and legislative chambers. The information is accurate, hence dependable. It presents a picture of trends and happenings that are of deep interest to every doctor and with which he should be reliably informed.

This comment is made for it is feared that many doctors overlook this section. To bring that section in more prominence, and which it deserves, it is hoped that the Editor may find it possible as well as advisable to transfer this section's position to one immediately following the editorial section and preceding "Medical News."

Whatever its position in each issue's form, every member should acquire the habit to look for that "Organization" section in our national journal. Read it carefully, ponder upon it and be guided by these facts in your professional work.

Malpractice

In order that members may better appreciate the value of membership affiliation with the Medical Society of the State of California, attention is directed to a communication in the Correspondence department of this issue. This member was sued for one million dollars—no small claim. As a State official his insurance carrier disclaimed liability. There was some misunderstanding also regarding service from the Attorney General's department. Had this member been without the services of the Legal Counsel of this special Medical Society he would have been put to several hundred dollars expense for services of a personal attorney. Read his appreciation.

You too may become involved in a dispute with your insurance company. As a member of this Society the services of a personal attorney will be at your disposal. Had you not better apply for membership now? Send to the State Secretary for an application blank.

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society presented their first clinic in the past five years on April 7, under the auspices of the postgraduate plan sponsored by the California Medical Association.

Vice-President Kramar presided. The clinic was held at the County Hospital. There was an attendance of nineteen.

The Orthopedic Clinic began at 10 a. m. and lasted until 1 p. m., with Dr. Donald King of San Francisco in charge. Doctor King had a great deal of material to work on and gave the members all that they could ask.

The Heart Clinic, from 1 p. m. until 5 p. m., was conducted by Dr. John Lewis of San Francisco, and was found to be very interesting and well presented. Doctor Wallace supplied many varied cases, the hall being filled at the end of the clinic by patients not being able to be presented.

The members felt that these clinics were very interesting and profitable, and voted thanks to the doctors for coming such a distance to us and at this time of the year.

LAWRENCE A. WING, *Secretary*.

KERN COUNTY

The Kern County Medical Society met at the Mercy Hospital in Bakersfield on Thursday evening, March 17, with Dr. Harry Lange presiding.

Dr. Jack Nicholson announced that the next meeting would be devoted to the subject of medical jurisprudence and would be a dinner meeting at the El Tejon Hotel, with members of the Kern County Bar Association present.

On May 4 the State Board of Public Health has arranged to have Dr. Udo Wile, Professor of Dermatology and Syphilology at the University of Michigan, speak on the *Treatment of Congenital and Prenatal Syphilis* at the El Tejon Hotel.

Doctors William Moore, Peter N. Root, and L. A. Packard reported on the recent Postgraduate Conference held at Santa Barbara, at which ten of the local members registered. They were very enthusiastic about its value, and Doctor Packard expressed the hope that the conference could be made an annual one for the four counties in the Third District. On the motion of Doctor Root, it was voted that a letter of thanks be sent to the Santa Barbara committee who arranged the conference.

Dr. Erle Henriksen of Los Angeles spoke on the *Treatment of Diseases of the Vagina and Cervix.* His talk was most practical and was of great interest to members of the Society. C. S. COMPTON, *Secretary.*

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MONTEREY COUNTY

The regular monthly meeting of the Monterey County Medical Society was held at the Santa Lucia Inn at Salinas on April 6. There were twenty-one members present.

Report of Dr. F. E. Wiebe, chairman of the Public Relations Committee, recommending that the secretary write a letter to the supervisors advising passing of a compulsory milk pasteurizing ordinance. A motion was made, seconded and passed, regarding this. A similar arrangement was advocated for the culinary workers as is in effect for the dairy workers.

A paper was presented by Dr. Howard Clark of Monterey on *Common Diseases of the Eye Seen in General Practice.* This was discussed by Doctors R. O. Griess and Wiley Reeves. H. R. LUSIGNAN, *Secretary.*

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SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Dave Dozier, on February 15, at the Auditorium on Twenty-ninth and L streets.

There were sixty-eight members and guests present.

Dr. Robert A. Scarborough of the Stanford University Medical School presented the paper of the evening, *Anorectal Infections.* Doctor Scarborough took up the symptoms, diagnosis, and treatment of the more common rectal lesions, such as cryptitis, fissure in ano, ulcers of the anal canal, abscesses, and fistula. The surgical treatment of these lesions was discussed in some detail. Discussion was opened by Doctor Ankele, and continued by Doctors Guttman, O. Johnson, and Empey.

Dr. P. Koch asked for the attitude of the Society regarding a new health insurance policy being offered in Sacramento, said policy offering both hospitalization and medical care. Doctor Koch also brought up the subject of acceptable medical fees for those physicians who might handle such work. After some discussion, a motion was made and so passed that the Sacramento Society for Medical Improvement go on record as not endorsing any fee schedule except as put out by its own members, if and as when needed. Doctor Van Den Berg asked that a copy of above discussed insurance policy be turned over to the Public Relations Committee for further study.

A motion was made and so passed that the Society send a bouquet of flowers and a message of congratulation to Dr. F. Sutliff on his eighty-fifth birthday.

Doctor Blanchard, Publicity Director of the Tuberculosis Association, discussed the recent articles on pneumonia which are appearing in the San Francisco *Call-Bulletin,* and asked the Society if it would be interested in carrying out a similar program in the local papers. Discussion by Doctors True, Scatena, Vance, Foster, O. Johnson, Empey, Guttman, Teall, Lee, and Gundrum. The matter was referred to the Public Relations Committee for further study.

Doctor Pulford, reporting for the Cancer Control Committee, discussed the work being done locally and asked the coöperation of members of the Society, especially in regard to speakers available from our membership, to assist the Women's Field Army in their publicity campaign.

G. E. MILLAR, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was called to order by President A. C. Boehmer on April 7 at 8:20 p. m. in the Medico-Dental clubrooms, Stockton. The meeting was preceded by the customary supper meeting held at the Hotel Wolf, at which there were twenty-six members and guests present. The paper of the evening was presented by Dr. C. D. Holliger of Stockton, who talked on the *Cancer Clinic as It Is Being Run by the San Joaquin County Hospital.*

The application of Dr. Curtis M. Galt of Manteca for membership in the San Joaquin County Medical Society was reported on favorably by the Admissions Committee and, there being no objections from the floor, Doctor Galt was declared a member. Petition of affiliation to the San Joaquin County Medical Society of Dr. Eugene Gay was received. This application was referred to the Admissions Committee.

Doctor Broaddus spoke on the essays submitted by those who had attended the Postgraduate Study Group. He stated that the judges had unanimously declared the paper of Dr. W. W. Fitzgerald of Stockton the best submitted. Doctor Fitzgerald was awarded a cash prize of $25. The runner-up was Dr. E. W. Hill of San Andreas. Both men were congratulated.

President Boehmer announced that the American Medical Association and the California Medical Association were conducting a survey on the amount of medical care that was being given. President Boehmer urged that this work be expedited and be as accurate as possible. He appointed the following committee to carry on the work: J. O. Eccleston (chairman), N. P. Johnson, L. J. Peterson, A. M. Tunnell, J. F. Doughty, C. W. Martin, L. E. Tretheway, A. K. Merchant, Linwood Dozier, E. W. Hill, H. S. Chapman, R. T. McGurk, E. L. Blackmun, G. H. Sanderson, C. M. Galt, and Samuel Hanson.

Dr. A. E. Anderson, councilor for this district, spoke on the importance of the survey of the American Medical Association and of the question of ethics and the county hospital situation as it confronts the physicians and the taxpayers of the state.

The scientific paper of the evening was read by Dr. E. Dickson, Professor of Bacteriology and Public Health at Stanford, whose paper was on *Coccidioides* and was illustrated by slides.

There being no further business to come before the Society the meeting was adjourned at 10:45 p. m., and refreshments were served. G. H. ROHRBACHER, *Secretary.*

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SAN MATEO COUNTY

The San Mateo County Medical Society met on Wednesday evening, March 23, in the banquet room of the Benjamin Franklin Hotel, Dr. Hartzell Ray presiding.

The Secretary made an announcement concerning an open house to be given by the local telephone company, to which the county society members have been invited.

An announcement was made concerning malpractice insurance, to the effect that two forms of policies with Lloyd's of London had received the approval of the California Medical Association. These policies bear the key numbers, NS 1131 5M1–38, and LP 4–4–8.

The President announced that a request had been made for the formation of a Woman's Auxiliary to assist in the work of entertaining guests for the annual session of the American Medical Association to be held in San Francisco in June. Dr. Erma Macomber was appointed a committee of one to carry out plans for the organization of an auxiliary.

An announcement was made that the following applications for membership had been received: Dr. Norman Fox, Dr. Werner Glaser, both of San Bruno; and Dr. W. C. Lynch of Daly City.

Mr. Burke, representing the Insurance Association of Approved Hospitals, made a brief talk concerning the present status of the Insurance Association and asked for the coöperation of the county society membership. His talk was supplemented by remarks from Doctor Cleary and the Secretary, requesting the County Society to give the Insurance Association of Approved Hospitals its full support.

The chairman of the evening, Dr. William A. Key, was introduced by the President. Doctor Key first presented Dr. Leon Parker, Chairman of the Subcommittee of the Regional Fracture Committee of the American College of Surgeons, who led an interesting discussion on the *Emergency Treatment of Fractures.* In connection with his talk, three soldiers from the Presidio demonstrated the emergency application of splints. Lieutenant-Colonel Bolibough was introduced and gave an interesting talk on the

Suspension Traction Treatment of Fractures of the Long Bone. Following this talk, Doctor Cleary discussed *Fractures of the Foot and the Importance of Early Weight Bearing.* Discussion followed the presentation of these subjects.

* * *

The meeting of the San Mateo County Medical Society of March 31 was held in the library of Mills Memorial Hospital. The entire board of directors was present.

The recenty inaugurated Health Service System of San Francisco, developed under the direction of Dr. Walter B. Coffey, was discussed. After consideration of, among other things, the fact that the legality of this plan was currently being tested in the courts, the board of directors unanimously voted its disapproval of participation in the plan on the part of county society members. It was suggested that the matter be presented later in open meeting of the Society. It was further suggested that Dr. Karl Schaupp and Dr. Carl Hoag be invited to discuss the subject at such a meeting.

The Secretary announced that many requests had been received concerning uniform fee schedules for physicians practicing in San Mateo County. Doctors Holmes, Gregory, and Bridgman were appointed as a committee to investigate the fee schedule published a few years ago, and to prepare and publish a new schedule.

The Secretary made an announcement concerning the survey being conducted by the American Medical Association on Medical Care in the United States; and of the request recently received from the California Medical Association that San Mateo County Medical Society conduct its part of the survey as soon as possible. Doctors Ray, Knorp, and Bridgman were appointed as a committee of three to carry on this survey.

The following motion was made, seconded, and unanimously carried: Members who become delinquent because of nonpayment of dues prior to April 15 automatically lose their membership and can only regain such membership by vote of the board of directors before membership can be reëstablished. J. Garwood Bridgman, *Secretary.*

SANTA CRUZ COUNTY

The first three meetings of 1938 of the Santa Cruz Medical Society have been very interesting and instructive.

At the January meeting Dr. Edward B. Shaw of San Francisco presented a paper on *Acute Infectious Diseases of Childhood* and especially emphasized the current accepted methods and indications for the various immunization procedures. Treatment was also mentioned, and the value of sulfanilamid in certain streptococcic, meningococcic, and gonococcic involvements was emphasized. The paper dealt with a subject of practical importance, and was of value to those of us in general practice.

The February meeting was in the form of a joint meeting with the Santa Cruz County Bar Association, at which time we were the guests of the Bar Association. Mr. Hartley Peart of San Francisco was the speaker of the evening, and the subject of his remarks had to do with the mutual problems confronting members of the legal and medical professions at this time. Such problems as state medicine, increasing malpractice suits, inroads of cultists, and antivivisection activitists were emphasized. Mr. Peart urged a closer coöperation between the two professions and also suggested the importance of a more active interest in political programs.

Dr. Howard Morrow, President, and Dr. F. C. Warnshuis, Secretary, of the California Medical Association, were present at a joint meeting of the Santa Cruz and Monterey County societies, held at the Club Rio Del Mar, Aptos. Doctor Morrow discussed several dermatological subjects of scientific interest, mentioned the present campaign being waged against venereal diseases and informed those present of the relative merits of the various routines in the treatment of syphilis. Doctor Warnshuis discussed matters of pending importance to the medical profession, especially mentioning the proposed antivivisection bill, efforts to open county hospitals to pay patients, and the so-called chiropractic initiative.

At the March meeting, Dr. J. T. Harrington was elected first vice-president to succeed Dr. Reginal Rood, who has recently left Santa Cruz to assume a position on the staff of the Napa State Hospital.

A committee was appointed at the March meeting to confer with the authorities relative to the information of a visiting staff at the Santa Cruz County Hospital.

Samuel B. Randall, *Secretary.*

TULARE COUNTY

The Tulare County Medical Society met on Sunday evening, March 13, at seven o'clock at Motley's Café. Dr. E. R. Zumwalt presided.

Doctor Cronemiller, program chairman, introduced the guest speaker of the evening, Dr. Donald King, orthopedic surgeon of Stanford University, who spoke on *Backache.* His talk was illustrated by diagrammatic sketches and demonstration. A general round table of discussion followed.

Dr. A. E. Anderson, district councilor, was present and requested an arranged Association evening meeting for discussion of organization affairs. He outlined the active measures at present confronting the California Medical Association Council and answered many questions.

Doctor DeBusk of Visalia, a recent newcomer, was present and was introduced.

* * *

The Tulare County Medical Society held a joint meeting with the Tulare County Bar Association at Motley's on Sunday evening, March 27.

The Hon. Hartley F. Peart, Attorney at Law for the California Medical Association, spoke on *Narrowing Fields of Praetice.*

An excellent group was in attendance of both doctors and lawyers. It consisted of Doctors Falk, Guido, Ginsburg, Weiss, Matthias, Seligman, Cronemiller, Zumwalt, Zeller, Mr. Peart, Kohn, Brigham, A. Miller, N. Miller, Parkinson, Wiens, DeBusk, Hill, Campbell, Ambrose, Powell, Seiberth, Rosson, and Attorneys E. C. Farnsworth, Dan McFadzean, Earl W. Westcott, John Locke, Jr., R. K. Meyers, H. C. Millspaugh, Judge Glenn Moran, W. G. Machetanz, LeRoy McCormick, J. E. Greene, Leroy G. Smith, Judge Frank Lamberson, Walter Haight, Waldo Burford, Lee Lindsay, Homer Wood, Gareth W. Houk, N. F. Bradley, C. L. Bradley, Ward G. Rush, George F. Gill, John P. King, J. T. Crowe, Jim Abercrombie, O. O. Davis, James M. Burke, and Adolph Feierbach.

Karl F. Weiss, *Secretary.*

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, March 8. There were thirteen members present. Doctors Bishop, Gilman, Moore, Witten, and Harker were guests.

Doctor Wylie explained the proper procedure for reporting venereal diseases and contacts.

Doctors Gronhovd and Wylie attended the meeting of the Public Health League on March 3 at the Mona Lisa Café in Los Angeles. Doctor Wylie gave a brief report of the meeting and warned the members to be on watch for the Humane Pound Act, the Act to open county hospitals to General Public Use, and the Public Health Liability Act.

Doctors Homer, Sterling Clark, and the interns from the county hospital presented a series of four cases of coccidioides.

* * *

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, April 12. There were fourteen members present. Doctors Gilman, Moore, Bishop, Witten, and Harker were guests.

The following communications were read: The State Secretary's monthly letter; a communication from the

Judicial Council of the American Medical Association; a letter in regard to the Cancer Army Campaign; one from the Massachusetts Indemnity Company regarding group insurance; and a letter in regard to the study and provision of medical care.

Doctor Strong extended thanks from the Ventura County Boy Scouts Council for the work of physicians in examining the boys sent to camp.

The Secretary briefly outlined the purpose of the study for provision of medical care, and passed out blanks to the various members present.

Doctor Wylie discussed the various problems of the Public Health Department and their relationship to the general practitioner. He spoke on communicable diseases, sanitation, laboratory facilities, Public Health nursing, and tuberculosis. He asked for volunteers to make an occasional call to outlying districts to make a diagnosis for the Health Department in certain types of communicable diseases.

The question of the survey for high school seniors throughout the county was discussed. The general feeling was that the survey should be restricted entirely to the high school seniors, and should not include any other school employees.

A motion was made by Doctor Smolt, seconded by Doctor Gronhovd, that we do not hold any May meeting, as the date conflicts with the State meeting at Pasadena.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (95)

Alameda County

Bernard O. Burch
Bernard E. Halligan
Harold Shanks
Francis D. Shanley

Fresno County

Ralph C. Cloninger
Menno S. Gaede
Harold G. Soucey
John E. Young

Humboldt County

David Nathaniel McInturff

Kern County

Alvin Walter Gaede

Los Angeles County

Floyd K. Anderson
Milford X. Anderson
Albert N. Anton
Claude E. Babcock
Fred F. DuPree
Harold F. Galbraith
A. H. Galvin
Harold R. Hennessy
Leon Jones
Leon Krohn
L. D. Mahannah
Joseph Marco
James Acker Mattison
Richard W. Moore
Charles Joseph Olhoffer
Royal C. Payne
Allen R. Schmidt
Ralph L. Schroeder
Y. K. Slocum
Rodney H. Snow
Paul Steinberg
Leo H. Wallendorf
Harry A. White
Angus Wright

Mendocino-Lake County

Robert G. Brankamp
John H. Lloyd
Dallas L. Wagner

Monterey County

Garland K. Hargrove

Orange County

A. E. Alne
Dean C. Brown
Isaac Newton Kraushaar
Carl J. Paul
Harold V. Westherman

Placer County

Edwin Slater Peeke

San Benito County

John J. Haruff

San Bernardino County

Harry Alfred Tyerman
Samuel Zelman

San Diego County

William C. Black
John D. McCausland
Roy A. Omer

San Francisco County

Clarence W. Adams
Thomas Addis
George H. Anderson
Bernhard Berliner
Joseph H. Boyes
J. Lawrence Brown
Kurt Elsbach
Clement A. Fogerty
Edmund P. Gaynor
Arnold Manor
Arthur Carol McKenney
Eugen Ostwald
Theodore H. Paoli
Louis J. Oviedo
John F. Rickard
Charles F. Sweigert
Henry M. Weyrauch, Jr.

San Joaquin County

Curtis M. Galt

San Mateo County

Richard H. Ames
Joseph M. Dallal
P. W. Eliason
Gerald F. Fairbairn
Joel H. Hanson
John B. Lagen
Freda Meyerfeld
Ezra Richards
Mayo H. Soley

Santa Barbara County

Clark Brown
James W. Dalton
Helen Hart

Santa Clara County

Gordon Billingsley
Wayne Chesbro
Bernard H. Gilbert
Robert W. King
Carl D. Leonard
Thomas P. Lyon
Max E. Pickworth
John W. Wear

Santa Cruz County

Daniel D. Smith

Shasta County

Rollin M. Falk

Siskiyou County

J. Randolph Barr

Solano County

Johan J. Couperous
Felix J. Rossi, Jr.

Tulare County

Lewis L. Seligman

Yuba-Sutter County

John Wesley Lindstrum

Transferred (7)

Henry A. Beaudoux, from Alameda County to Santa Clara County.

Robert V. Carter, from Santa Barbara County to Los Angeles County.

Curtis M. Hanna, from Shasta County to San Diego County.

William F. B. Harding, from Sacramento County to Marin County.

Walter N. Levin, from Fresno County to Kings County.

Joseph M. Swindt. from San Bernardino County to Los Angeles County.

Grace F. Thomas. from Los Angeles County to Mendocino County.

Resigned (4)

Leona M. Bayer, from San Francisco County.
F. Edwyn Garfinkle, from San Francisco County.
Henry W. Newman, from San Francisco County.
Wilfred L. Olsen, from San Francisco County.

In Memoriam

Blond, Harry Hyman. Died at Los Angeles, March 11, 1938, age 32. Graduate of McGill University Faculty of Medicine, Montreal, 1931. Licensed in California in 1932. Doctor Blond was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Dickerson, Harry William. Died at San Diego, March 24, 1938, age 63. Graduate of Washington University School of Medicine, St. Louis, 1901. Licensed in California in 1929. Doctor Dickerson was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

Goodman, Emanuel. Died at San Francisco, February 22, 1938, age 82. Graduate of the Medical College of Ohio, Cincinnati, 1892. Licensed in California in 1895. Doctor Goodman was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✝

Loehr, Bert E. Died at San Jose, April 12, 1938, age 57. Graduate of Hahnemann Medical College and Hospital of Philadelphia, 1909. Licensed in California in 1910. Doctor Loehr was a member of the Santa Clara County Medical Society, the California Medical Association, and the American Medical Association.

✝

Orbison, Thomas James. Died at Los Angeles, March 26, 1938, age 71. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1898. Licensed in California in 1907. Doctor Orbison was a retired member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Payton, William Bruce. Died at Riverside, January 7, 1938, age 81. Graduate of the University of Michigan Medical School, Ann Arbor, 1881. Licensed in California in 1892. Doctor Payton was a member of the Riverside County Medical Society, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS.....President
MRS. FRED ZUMWALT.....Chairman on Publicity

News Letter

Dear Auxiliary Members:

On March 17 a group of women, twelve in number, met to discuss plans for an Auxiliary to the Merced County Medical Society. They were interested, for then and there they organized. From Merced three of their officers were chosen: For President, Mrs. E. M. Soderstrom; for First Vice-President, Mrs. C. C. FitzGibbon; for Treasurer, Mrs. McNearney. Mrs. A. B. Bigler of Chowchilla was elected Secretary, and Mrs. A. V. Andrews of Livingston, Second Vice-President.

When Mrs. Hobart Rogers of Oakland assumed the presidency her aim was 100 per cent membership. No one woman could accomplish that desire in the short space of one year, but surely Mrs. Rogers must feel satisfied with the results of her administration. The membership has increased four hundred and fifty and over in less than a year. Four new county Auxiliaries have been organized thus far. I say thus far, because San Mateo County is going to join us officially on April 20, at which time officers will be elected.

At the meeting held April 7 "to talk matters over," so to speak, Mrs. R. J. Reitzel of 37 Crystal Springs Road, acted as chairman and Mrs. J. G. Bridgman of 433 Clarke Drive, San Mateo, as Secretary.

Apparently all counties have awakened and have realized that they cannot afford to remain outside an organization that is working for just one object—and one that concerns all of us vitally—the maintenance of the high standards that the profession of medicine has always justly held.

The entire membership welcomes these Auxiliaries, that of Merced, which is already a part of our organization, and that of San Mateo, which is soon to be. It is gratifying to have them become a part of us.

Cordially yours,

MRS. FRED H. ZUMWALT.

Component County Auxiliaries

Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met on Tuesday, March 22, at the Woman's Athletic Club for its regular luncheon meeting, with Mrs. Eliot Alden presiding, and ninety-eight members present.

Most of the program was devoted to a talk by Mr. Ben H. Read, who gave a most interesting résumé on pending legislation. Mrs. B. H. Sherman gave a report on the library, and Mrs. Karl von Hagen read a splendid paper on medical highlights, dealing with certain forms of quackery.

An announcement was made that our membership chairman, Mrs. Mark Albert Glaser, and her committee have added one hundred and fifty new members to our roster this year, making a total membership of 635.

MRS. ROBERT L. CARROLL, *Corresponding Secretary.*

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Marin County

The monthly meeting of the Woman's Auxiliary to the Marin County Medical Society was held, March 24, at the Marin Golf and Country Club.

After dinner the members gathered in the lounge to hear a most interesting travelogue by Mrs. H. O. Martin of San Francisco. Mrs. Martin spoke on *Around the World on a Freighter.* Her presentation was not only interesting but amusing as well, particularly the account of her stay in both Norway and Sweden.

The most important part of the business meeting that followed was the election of the nominating committee.

MRS. BERNARD J. CONROY, *Chairman of Publicity.*

✲

Orange County

On Tuesday, April 5, the Woman's Auxiliary to the Orange County Medical Society, met at the home of Mrs. Claude Steen of Fullerton.

Following the business session, the meeting was turned over to Mrs. Arthur Wies, Chairman of the Public Health Committee, who presented Dr. D. A. Harwood of Santa Ana. He spoke of the more recent and encouraging features in the control and care of cancer, emphasizing the importance of early diagnosis.

Preceding the program a short memorial service was conducted for Dr. James Boyd, pioneer physician of Orange County, who recently passed away.

At the May meeting to be held at the Pacific Coast Club in Long Beach, the following nominees will be voted upon: For President, Mrs. Hiram Currey; for Vice-President, Mrs. E. H. Kersten; for Secretary, Mrs. J. W. Price, and Mrs. E. J. Steen, Treasurer.

MRS. K. H. SUTHERLAND, *Publicity Chairman.*

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Riverside County

The Woman's Auxiliary to the Riverside County Medical Society held its regular meeting on March 15 at the home of Dr. and Mrs. W. W. Roblee. About twenty members were present. Mrs. E. T. Bartholemew presented the program of the Women's Army for the Prevention of Cancer. Miss Celia Crosse discussed the local health department and its problems and plans. Miss Crosse is a public health nurse in the department.

Following the meeting the members of the Medical Society joined the group for a pleasant social hour. Piano

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

solos by Mrs. Charles Miller and vocal selections by Mrs. Wayland Coon were enjoyed. Refreshments were served by the hostess and her committee.

Mrs. T. A. Card, *President.*

Sacramento County

The home of Mrs. Richard O. Schofield was the setting for the March meeting of the Sacramento Auxiliary on Tuesday evening, the 15th.

A business meeting was held with Mrs. William J. Van Den Berg, President, presiding.

Mrs. Hilton Lusk gave a reading of a modern play. Refreshments were served at the close.

Assisting hostesses were: Mesdames Cordes Ankele, James Coyle, W. H. Gibbons, H. M. Kanner, James T. Vance and Gustave Wilson.

Mrs. Hugh Carmichael, *Chairman of Publicity.*

San Diego County

San Diego County held two of its most important meetings during the past month. On March 8, Dr. Lyell C. Kinney, a Past President of the California Medical Association, and chairman of our Advisory Committee, spoke on legislation concerning the medical profession which will come before the voters this fall. He urged us to begin now to form a legislative set-up which will carry over into the next administration, in order that we may be ready when the County Medical Society calls upon us.

On March 18, our third annual Health Education program was held in the House of Hospitality, Balboa Park, with sessions in the afternon and evening. In order to promote the organization of the Women's Field Army for the Control of Cancer, we joined forces with them, presenting Dr. C. C. Little, Managing Director of the American Society for the Control of Cancer, as the main speaker. A talk on *Hearts, Young and Old,* and a movie, showing the work of the Visiting Nurses, concluded the afternoon session.

In the evening, Dr. Donald Davie, Director of the State Health Division of Venereal Diseases, spoke on *Syphilis,* and showed movies to make his words more graphic. Dr. Carl Howson spoke on *Tuberculosis.* The local Vice-Commander of the Field Army told of its work.

The city captain of the new cancer organization in San Diego is a member of our Auxiliary and some of our members are working on the Advisory Board. We hope to do our share toward its success. Several of our members are active in the Visiting Nurses' Association.

For April 12, our Program Chairman, Mrs. W. C. Cooke, has arranged an unusually interesting day. Following the regular luncheon at the Men's University Club, we will adjourn to the pool for crippled children, where a demonstration of the work done there will be given. The mode of operation of the Society for Crippled Children, in which we carry a club membership, its relationship to the State Health Department and the social welfare angles involved, will be explained. The Sunshine School, which gave the land for the "pool," and which is run in connection with the Helping Hand Home for Children, will also be visited. Several of our members do volunteer service at the pool.

San Diego will be well represented at both the State Convention in May at Pasadena, and also at the meeting of the American Medical Association to be held in San Francisco in June.

We have enjoyed the State Membership Trophy, which we have held during the past year. We are sorry to part with it, but our 85 per cent increase could, naturally, not be repeated. We hope the Auxiliary which receives it will take pride in displaying it as we did.

Mrs. Elliot G. Colby, *President.*

San Francisco County

The annual meeting of the Woman's Auxiliary to the San Francisco County Medical Society will be held on Tuesday, April 19, at 2180 Washington Street. Mrs. William H. Sargent of Oakland, a Past State President, will install the newly elected county officers, as follows: Mrs. Thomas E. Gibson, President; Mrs. Edmund J. Morrissey, First Vice-President; Mrs. A. Lincoln Brown, Second Vice-President; Mrs. Fred D. Fellows, Recording Secretary; Mrs. Wilber F. Swett, Corresponding Secretary; Mrs. John D. Humber, Treasurer. Also, newly elected directors as follows: Mrs. William C. Voorsanger, Mrs. E. S. Kilgore, and Mrs. Rea E. Ashley. Directors continuing in office are: Mrs. A. S. Musante, Mrs. Fred H. Zumwalt, Mrs. Harry R. Oliver, Mrs. Frank H. Rodin, and Mrs. Otto Laist.

Dr. J. C. Geiger, City Health Director, will address the Auxiliary on the *Organization and Function of the Public Health Department.*

Following the business session, the officers and directors will give an informal tea in honor of the retiring president, Mrs. Hans Barkan. Miss Helen Zumwalt, gifted daughter of Dr. and Mrs. Fred H. Zumwalt, will be the guest artist for the afternoon, and will render a delightful selection of songs.

The study group will hold their final meeting on April 25, with a luncheon given by Mrs. Julius Sherman at her home in Atherton. Dr. Henry Harris will be the guest of honor, and will review his recent book, *California's Medical Story.* Mrs. Sherman has conducted the round-table discussions on medical topics twice monthly during the current year.

Mrs. Harry R. Oliver, *Publicity Chairman.*

Santa Barbara County

Santa Barbara Auxiliary has announced the date of its annual spring bridge tea. It is to be held on Friday, April 22, at the newly reopened Samarkand Hotel. Mrs. Edward L. Markthaler and Mrs. William R. Hunt will be co-chairmen. A large committee will assist, including Mrs. C. T. Roome, President; Mrs. Harold Schwalenberg, Mrs. Sheldon Paine, Mrs. Edward L. Lamb, Mrs. John Van Paing, Mrs. Kent Wilson, Mrs. Hugh Freidell, Mrs. Franklin R. Nuzum, Mrs. Alfred T. Wilcox, and Mrs. Henry J. Profant. Mrs. Alma Spreckels of San Francisco, who has recently taken over the Samarkand Hotel and has had it redecorated by noteworthy artists, promises us a lovely party.

The Auxiliary is taking part in the program for Cancer Control Week. Dr. Susanne Parsons, chairman of the local committee, spoke of the campaign at the March meeting. Six members will take charge of a table on State Street for the membership drive in the Cancer Control Campaign on Saturday, April 9.

On Monday, March 14, we were honored by a visit from Mrs. Rogers and Mrs. Hall. The meeting took the form of a buffet luncheon at the home of Mrs. Harry DeVigne, and twenty-five members were present. Mrs. Rogers' talk was enthusiastically received by the members, and Mrs. Hall also had a brief message for us. Our guests afterward enjoyed a tour of the Blakesly Botanical Gardens, where the ceonothus spread their lacey blossoms overhead, and next morning left for a visit to the San Luis Obispo Auxiliary at Paso Robles. On the trip they were accompanied by Mrs. Edward L. Markthaler, District Councilor. They had lunch at the Santa Maria Inn with Mrs. O. C. Jones, a member from that city.

Mrs. H. E. Henderson, *Publicity Chairman.*

Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met at luncheon at the Rio Del Mar Country Club. Our President, Mrs. Alfred L. Phillips, presided at this March meeting.

We had a small but very interesting meeting, with Mrs. Lawrence A. Knox of Carmel as guest speaker.

The following committee chairmen were elected: Public Relations, Mrs. F. H. Shenk; Public Health Education, Mrs. J. D. Fuller; and Hygeia, Mrs. G. Bunney.

Our next meeting will be purely social. Mrs. G. Bunney has graciously offered her home for the occasion.

Mrs. R. C. Alsberge, *Chairman of Publicity.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

Hawaii Territorial Medical Association, Honolulu, May 20–22, 1938. Douglass B. Bell, M.D., Dillingham Building, Honolulu, T. I., Secretary.

Texas State Medical Association, Galveston, May 9–12, 1938. Holman Taylor, M.D., 1404 West El Paso Street, Forth Worth, Texas, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of May is as follows:

Thursday, May 5—KECA, 11:00 a. m., The Road to Health.
Saturday, May 7—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 12—KECA, 11:00 a. m., The Road to Health.
Saturday, May 14—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 19—KECA, 11:00 a. m., The Road to Health.
Saturday, May 21—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 26—KECA, 11:00 a. m., The Road to Health.
Saturday, May 28—KFI, 10:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.

Medical Cyclotron Framework in Place at University of California.—With 155 tons of its steel framework already in place, the new medical cyclotron of the University of California, designed to produce radio-active ammunition for the war against cancer, leukemia and other malignant diseases, is beginning to assume shape. It will be ten months to a year, however, before all of the involved and intricate mechanisms of the cyclotron will be in place and ready for operation.

Within the next two months it is expected that the poles and copper windings, between which the vacuum chamber, the "core" of the cyclotron will be placed, will be in position. Thereafter will come the vacuum chamber itself, together with the maze of conduits and wiring necessary for the operation of the monolithic atom smasher. All of these conduits will be in place in the floor of the cyclotron room before it is finally covered with concrete.

When completed the cyclotron will have an over-all height of 11.6 feet, and will be between 210 and 220 tons in weight.

The framework itself is made up of a number of steel plates, each one and six-tenths tons in weight. It was found more practical to have the framework made of these plates rather than single castings, as this made shipment much easier. The plates are being welded together however, to prevent separation and dislodgment in the event of an earth or other disturbance.

The cyclotron is in its own specially constructed laboratory, in which is already housed a small biological laboratory for premilinary experimentation.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Southern California Medical Association.—The ninety-eighth semiannual meeting of the Southern California Medical Association was held on April 8 and 9, in the Mission Inn, Riverside. The following program was presented:

Friday Afternoon Session

Gonorrheal Vulvovaginitis in Children, Erle Henriksen, M.D., Los Angeles.
Discussion: Eugene F. Hoffman, M.D., and Phillp E. Rothman, M.D., Los Angeles.

Pathologic Bleeding from Ruptured Corpus Luteum Cysts, Hall G. Holder, M.D., San Diego.
Discussion: Bernard J. Hanley, M.D., and Foster K. Collins, M.D., Los Angeles.

The Significance of Bleeding from the Rectum, Kenneth E. Smiley, M.D., Los Angeles.
Discussion: William H. Kiger, M.D., Los Angeles; Bon O. Adams, M.D., Riverside.

The History of Syphilis, H. Sutherland Campbell, M.D., Los Angeles.
Discussion: Richard D. Evans, M.D., Los Angeles; George Dock, M.D., Pasadena.

Friday Evening Session

California's First Great Medical Scientist, Chauncey D. Leake, Ph.D., Professor of Pharmacology, University of California, San Francisco.

Saturday Morning Session

Some Dangers of the Intracranial Use of Thorotrast, David Reeves, M.D., Los Angeles.
Discussion: Richard T. Taylor, M.D., and Kenneth S. Davis, M.D., Los Angeles.

A Plea for the Early Recognition of Left Ventricular Failure, William P. Thompson, M.D., Los Angeles.
Discussion: James R. Sanford, M.D., Pasadena; Ralph M. Tandowsky, M.D., Los Angeles.

Headache, W. Howard Halsey, M.D., San Diego.
Discussion: Frank E. Detling, M.D., and Joseph B. Stevens, M.D., Los Angeles.

Acute Pancreatitis, E. Eric Larson, M.D., Los Angeles.
Discussion: Ray B. McCarty, M.D., Riverside; Charles T. Sturgeon, M.D., Los Angeles.

Saturday Afternoon Session

Tuberculosis of the Appendix, Thomas A. Card, M.D., Riverside.
Discussion: Carl R. Howson, M.D., and Verne C. Hunt, M.D., Los Angeles.

Peritoneoscopy—The Differential Diagnosis of Abdominal Malignancy by Biopsy, John C. Ruddock, M.D., Los Angeles.
Discussion: Clarence G. Toland, M.D., and John W. Budd, M.D., Los Angeles.

The Effects of Histone Insulin in the Treatment of Diabetes Mellitus, Percival A. Gray, M.D., Santa Barbara.
Discussion: William C. Boeck, M.D., and Howard F. West, M.D., Los Angeles.

The Demonstration by Radiological Methods of the Mucous Membrane Pattern of the Gastro-Intestinal Tract and Its Defects, Wilbur Bailey, M.D., Los Angeles.
Discussion: Lyell C. Kinney, M.D., San Diego; Milton J. Geyman, M.D., Santa Barbara.

The officers for 1938 are as follows:
William H. Barrow, M.D., San Diego, President.
Alvin G. Foord, M.D., Pasadena, First Vice-President.
William P. Corr, M.D., Riverside, Second Vice-President.
John B. Doyle, M.D., Los Angeles, Secretary-Treasurer.
Councilors—Frank R. Nuzum, M.D., Santa Barbara; Robert W. Langley, M.D., Los Angeles; Merrill W. Hollingsworth, M.D., Santa Ana; William H. Barrow, M.D., ex officio; John B. Doyle, M.D., ex officio.
Board of Governors—F. M. Pottenger, M.D., Los Angeles; Egerton L. Crispin, M.D., Los Angeles; Joseph M. King, M.D., Los Angeles; Joseph K. Swindt, M.D., Pomona; Charles T. Sturgeon, M.D., Los Angeles; Paul E. Simonds, M.D., Riverside; Raymond G. Taylor, M.D., Los Angeles; Fred B. Clarke, M.D., Long Beach; Carl R. Howson, M.D., Los Angeles; Bon O. Adams, M.D., Riverside; H. Douglas Eaton, M.D., Los Angeles.

New York Bans Psittacine Birds.—The Public Health Council of the State of New York at its meeting in New York City on February 18 adopted the following amendment to Chapter II of the State Sanitary Code:

Regulation 38. Importation, Breeding, or Sale of Psittacine Birds Prohibited. The importation, breeding or sale of birds of the psittacine family is hereby prohibited, provided, however, that the importation and breeding of such birds for scientific research or exhibition in public zoological gardens may be permitted subject to the approval of the state commissioner of health. This regulation is to take effect on the first day of March, 1938.

More California Marriages in 1937.—Marriages in California for the year have been tabulated, with a total of 64,397 as compared with 60,197 in 1936, an increased number of 4,200 or 6.98 per cent. Of the ten counties having a population of 100,000 or more in 1930 all showed increased numbers of marriages and in those twenty-one counties having populations of more than 50,000 only one showed a decrease. In the group from 10,000 to 50,000 population, there were increases in seventeen of the twenty-three counties, but in the group of counties having small populations, those with less than 10,000 inhabitants, only five showed increased numbers of marriages, while five showed decreased numbers and four showed no change. The California marriage rate in 1937 is 9.9 per 1,000 inhabitants as compared with a rate of 9.4 per 1,000 estimated population in 1936. Since 1932, when the number of marriages reached its lowest point of 43,164 with a rate of 7.3 per 1,000 estimated population, there has been a steady increase. There has been a registration increase of 48.7 per cent in numbers and 35.6 per cent in rate.

Another Human Death in Los Angeles from Rabies.—A laborer in Los Angeles, aged fifty-seven, died in the General Hospital of rabies on March 12, 1938. The history of the case, prepared by Dr. Hyman I. Vener, Assistant Epidemiologist in the Los Angeles City Department of Public Health, reveals that the patient was bitten on the second finger of the right hand about February 22. He had been bitten by a small brown dog which was lying in the street, apparently dead. When the laborer attempted to pick up the sick dog, the animal bit him and ran away. No attention was paid to the bite and no thought was given to the matter until after the onset of the illness.

A brown spaniel dog, at the same time, was responsible for biting seven other persons, three of whom were in the vicinity of the accident to the laborer. It is, therefore, reasonable to presume that the same dog was responsible. It is quite probable that this event occurred prior to the time indicated, as considerable difficulty was experienced in obtaining reliable data because of the violent illness of the patient who died within twenty-four hours after entering the hospital.

Herzstein Lectures.—Stanford University and the University of California take pleasure in announcing the sixth course of the Morris Herzstein Lectures to be given by Dr. George W. Pickering, Department of Clinical Research, University College Hospital Medical School, London, England. Through the provisions of the will of the late Dr. Morris Herzstein of San Francisco, these lectures are held in San Francisco under the auspices of the two universities.

Doctor Pickering will give three lectures at 8:15 p. m. on the dates given below at the University of California Extension Division, 540 Powell Street, San Francisco, as follows:

Monday, May 23—"The Problem of High Blood Pressure in Man."

Tuesday, May 24—"Experimental Hypertension."

Wednesday, May 25—"The Renal Pressor Substance."

Members of the profession, including practitioners and medical students and other interested persons are cordially invited to attend.

In addition, he will give a popular lecture at luncheon on:

Thursday, May 26—"The Biological Significance of Pain."

The place of the luncheon will be announced later.

(Signed): Loren R. Chandler, M.D., *Dean*,
Stanford University School of Medicine.
Langley Porter, M.D., *Dean*,
University of California Medical School.

Trailer Hospital Newest Departure in United States Medicine.—The day when a patient can call up the Board of Health and order a trailer hospital sent to his door for an operation on an unruly kidney may be at hand.

It has already arrived in Texas, according to Dr. Guy S. Millberry, Dean of the College of Dentistry, University of California, who has, himself, completed a six months' trailer trip through the United States and a portion of Canada in an effort to gain first-hand information on the public health phases of dentistry everywhere.

The hospital trailer was found in the little city of Ysleta, Texas, and is owned by a Doctor Love, according to Doctor Millberry. While it is equipped chiefly for obstetrical work in the rural sections, it can accommodate other types of cases. In some respects it is far superior to a number of the smaller, isolated hospitals throughout the country, Doctor Millberry says. The trailer hospital works within a range of fifty miles or so around Ysleta and accomplishes from thirty to thirty-five deliveries a month. A trained nurse accompanies it as a rule, but additional technicians can be accommodated when needed.

Hospital Payment Plans.—In an effort to help both the doctor and the patient, several plans of payment have recently been announced by the Berkeley General Hospital. In order to avoid confusion in the minds of the profession, they are outlined below:

1. *Cash Payment in Advance.*—Traditional plan of collecting one week in advance.

2. *Patient's Installment Plan.*—The admission of responsible private patients with a small down payment and small weekly or monthly installment payments.

3. *Collection of Physician's Fee.*—The extension of the installment plan to add doctor's professional fees to the patient's installment contract, in any case where the doctor might feel that the hospital is in a better position to collect from the patient because of the security behind its written agreement and its follow-up system. This Medical Credit Service is entirely optional with the physician and is taken up with the patient only when requested by the physician.

4. *Part-pay Medical and Dental Clinics.*—This plan is not open to private patients, but provides only for the care of deserving patients who, upon strict social service investigation and with the consent of the last attending physician, have been found eligible for out-patient care or hospitalization by the clinic staff, at reduced part-pay rates in small installment payments.

Lectures on High Blood Pressure.—High blood pressure and chronic headache, two baffling complaints that seem to have become a part of American tension, love of speed, overwork and kindred features of modern life, are to be detailed in a popular manner by a world authority on these complaints, in the sixth course of the Morris Herzstein Lectures under the auspices of the University of California and Stanford University Medical Schools. The lecturer is Dr. George W. Pickering, Department of Clinical Research, University College Hospital Medical School, London, England. The lectures on high blood pressure are to be given at the University of California Extension Division Auditorium, 540 Powell Street, but the headache talk will be made the feature of a luncheon to be held in the Rose Room of the Palace Hotel. Both lectures and luncheon are open to the public. There will be a charge for the latter event.

The dates of the lectures are May 24, with the subject, "The Problem of High Blood Pressure in Man"; May 25, "Experimental Hypertension," and May 25, "The Renal Pressor Substance." The luncheon will be held on May 26.

Doctor Pickering, a profound student on the subject of high blood pressure, has written a number of papers on the subject which have been given wide circulation.

The lectures are provided in the will of Dr. Morris Herzstein, pioneer California practitioner and associate of Dr. William Watt Kerr and Dr. Herbert Moffitt. He left his estate to the medical schools of the two universities, and it is through this that the lectures are endowed. They are open to all members of the profession and all others interested.

Dentist Appointed to State Board.—Governor Frank F. Merriam has appointed V. A. Rossiter, D.D.S., of Santa Ana, to membership on the California State Board of Public Health. Doctor Rossiter is the eighth member of the Board, his appointment having been provided through an amendment to Section 372 of the Political Code enacted by the 1937 session of the Legislature.

Heart Disease.—The crude death rate for heart disease, which ranks first among all the causes of death, dropped slightly in 1937. A bright spot in the heart disease mortality record is the fact that the rate is declining among young people where most of the deaths are caused by chronic endocarditis, which, in turn, is most often induced by infectious diseases, chiefly acute rheumatism, streptococcic infection, and syphilis. The trend is still upward for cardiac diseases of the senescent or arteriosclerotic type which are predominant in the higher age ranges of life and which are, for the most part, the result of the inevitable breakdown of the organism with advancing age.

Eye Health to Be Studied at Summer Session.—Annette M. Phelan, Ph. D., Associate in Education, National Society for the Prevention of Blindness, has accepted an invitation to offer two courses in eye health education in the University of California Summer Session, June 27 to August 5. One course, Eye Health of the School Child, will deal with educational and health problems involved in visual defects among school children; and the other course, Eye Health in Teacher Education, will take up the eye health content of curricula for teacher education in the light of contributions by the sciences, teaching practices and classroom conditions.

Miss Phelan has been instructor in Health Education at Columbia University since 1933. She is the author of "A Study of School Health Standards," "Conserving the Sight of School Children," and a co-author of "Adventures in Living."

Summer Session Bulletins will be mailed upon request by the Dean of the Summer Sessions, 104 California Hall, Berkeley, California.

American Board of Obstetrics and Gynecology Examinations.—The oral, clinical, and pathological examinations for Group A and Group B applicants will be held in San Francisco, California, on Monday and Tuesday, June 13 and 14, 1938.

An informal dinner for the diplomates of this Board, their wives and others interested in the work of the Board, will be held at the Palace Hotel, San Francisco, on Wednesday evening, June 15, 1938, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, will address the group, and the successful candidates of the preceding two days' examinations will be introduced in person. Tickets, at $2.25 each, may be obtained in advance from Dr. Joseph L. Baer, 104 South Michigan Avenue, Chicago, Illinois, or at the door. Reservations should be made in advance if possible.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

National Health Council's Library on Public Health Literature.—Research workers from all parts of the United States used the facilities of the National Health Council Library, at 50 West Fiftieth Street, New York City, during the past year, and they were used also by education and nurses's training classes in local and nearby colleges. In 1937, the services of the library were made available more than 1,500 times to others than staff members of the seventeen organizations in the Council.

The library now contains more than six thousand volumes and thirty thousand pamphlets dealing with public health, sanitation, hygiene, and related subjects. More than five hundred medical and educational periodicals are received regularly from all parts of the world. As an aid to public libraries in the selection of books on health subjects, a list of approximately three hundred health books of interest to the general public is being compiled at present.

Active member agencies in the National Health Council include the following: American Society for the Hard of Hearing, American Heart Association, American Public Health Association, American Red Cross, American Social Hygiene Association, American Society for the Control of Cancer, Conference of State and Provincial Health Authorities of North America, Maternity Center Association, National Committee of Health Council Executives, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Society for the Prevention of Blindness, and the National Tuberculosis Association.

The United States Children's Bureau and the United States Public Health Service are advisory members of the Council. The American Nurses' Association and the Foundation for Positive Health are associate members.

New York State Enacts First Prenatal Health Law. As the *News* goes to press, comes word that Governor Lehman has signed the Twomey-Newell "baby health bill," recently passed by both houses of the New York State Legislature. New York thus has the honor of being the first state to enact a law for the protection of the unborn from congenital syphilis. It is, in fact, the first law of its kind to be enacted anywhere.

Thirteen thousand New York State babies, health authorities estimate, will be saved each year from death or disease by this law,[1] which requires all persons licensed to attend women in pregnancy to administer, or cause to have administered, a standard serological test, and to indicate on the birth or stillbirth certificate if such test was made. If the test has not been made, the reason for the omission must be shown, but results of such tests are not to be indicated on the certificate.

This life-saving legislation is an example of results obtained when all concerned work together. Drafted by social hygiene experts, proposed by the *New York Post*,[2] supported strongly by other New York newspapers, endorsed by official and voluntary health agencies, medical societies and civic groups, the bill moved forward steadily to passage by an overwhelming majority. . . .

As the prenatal bill was made into law, the Desmond-Breitbart bill for premarital examination for syphilis was being pressed forward to passage before the legislature adjourns. With the signing of this second bill, New York State will have taken two long steps toward stamping out syphilis within its borders. If every state will do likewise, "within a generation" need not be an extravagant prophecy as to when the "shadow" may "lift from our land."

Press Clippings.—Some news items from the lay press, on matters related to medical practice, follow:

Revenue Producing Apartments Can Be Made of Old Houses*

Outmoded residence properties, still structurally sound but no longer in demand by reason of excessive size, dated architecture, or neighborhood changes, may be converted into revenue-producing flats and apartments with funds available under the Property Improvement Credit Plan of the Federal Housing Administration.

Many residential landmarks are today but specters of past magnificence—deserted, falling into dilapidation, unwanted by the descendants of the original owner. These properties cannot be rented for homes in their present condition and serve only to gather unwanted taxes for the owners. Many have been demolished to ease the tax burden or with the hope of renting the vacant lot for some purpose.

By the expenditure of a reasonable amount of modernization many old homes may be remodeled into several small apartment units and placed on an income basis that will justify the expenditure.

The provisions of the National Housing Act as amended permit the insurance of modernization loans up to $10,000 on a single property. Repayments are made in equal

[1] Four thousand infants are now born annually in New York with syphilis, and these and nearly half the annual toll of 18,000 still births could be prevented by early diagnosis and treatment of the mother for this disease.

[2] In an editorial of January 5, and illustrated feature articles. Health and welfare agencies interested in promoting this type of legislation in their own states may secure a limited number of reprints of the *Post* articles upon request to the American Social Hygiene Association at 50 West Fiftieth Street, New York.

* Editor's Note.—This item may have suggestive value to smaller county medical societies, or branches of larger societies, contemplating "headquarters," and to those already in possession of a "headquarters home."

monthly installments over a period of as long as five years and thirty-two days. Charges for this credit are reasonable. The Federal Housing Administration insures the loans, and the funds are made available by private lending institutions, including banks, building and loan associations, finance companies and like agencies.

Extensive alterations necessary to remodel a dwelling for apartment purposes do not always require the service of an architect, but the scope of the work makes it desirable. Among the improvements eligible to be financed under the Property Improvement Credit Plan are: Installation of new heating, wiring and plumbing units and systems; redivision of floor space, painting and papering, and any other improvements that become an integral part of the building.

The exterior may require extensive alteration, which may also be financed with loans insured by the Federal Housing Administration. Brick work may be pointed up, roof repaired, or a new roof put on; porches removed, walkways and drives built, entrances cut, and the building painted.

Depreciation checked by modernization will pay off in income in many instances. A dwelling is not usually obsolete unless the structure is so unsound that it would be more economical to completely rebuild it.—Los Angeles *Evening News*, April 7.

* * *

Hospitalization Program Ruled Illegal by Webb

Corporations cannot engage in the practice of medicine.

Firms not licensed to insure cannot issue contracts providing for medical and surgical care and hospitalization.

Citing California law to this effect, Attorney-General Webb yesterday gave an opinion in San Francisco that the First National Protective Association of Los Angeles was obtaining members on a contract which violated a previous ruling that corporations cannot engage in the practice of medicine.

Opinion Transmitted

The opinion was transmitted to State Insurance Commissioner Carpenter following an inquiry concerning the association's operations by Inspector Risbrough of the Los Angeles office.

Webb held that the contract violated the State Medical Practice Act because it agreed to furnish medical service, which corporations are not permitted to do. It also violated the insurance law providing that only licensed insurers can issue policies, because the contract provided insurance, he said.

No Previous Complaints

"We have operated for five years without complaint," James W. Weitzman, president and general manager of the association, said. "If we are operating in a manner not in conformity with California law we shall have to revise our organization. We are now organized as a nonprofit corporation."

The association's offices are at 416 West Eighth Street.—Los Angeles *Times*, March 25.

* * *

Two Hundred Dogs Impounded in Los Angeles Quarantine

For the second day, crews of city humane department officers patrolled the city today to enforce the new quarantine against dogs.

Bertram E. Morse, inspector in charge of the Ann Street Shelter, and other humane officers reported that more than 200 dogs had been impounded in the drive under the direction or Dr. George Parrish, city health officer and chief advocate of the quarantine, and Dr. C. C. Warn, head of the humane department.

The animals in the various pounds will be held under observation for rabies for ten days. Then unlicensed or unclaimed dogs will be destroyed, and those with a license and found to be healthy can be reclaimed by owners.

General rules of the quarantine:

Dogs must be confined in the home or on the premises of the owner at all times; or must be kept on leash in the custody of a person over 15 years of age when in a public street or public place; or must be securely confined in closed automobiles on the public highway.

Claim Only Part of Dog Fees Used for Humane Department Work

With Los Angeles dog population under the restraint of a quarantine, dog owners today were renewing their demands for a more adequate humane department in the city and for more diligently enforced preventive measures as a means of effectively minimizing rabies danger.

Los Angeles' humane department facilities are inadequate and antiquated, it was pointed out, despite the fact that dog owners of the city pay into the public treasury annually a sum in excess of $200,000 in dog license fees.

This sum, it is contended, is ample in every way to provide an adequate humane department, large and efficient enough to cope with any situation.

Claim Fund Diverted

The rub, according to the dog owners, is that much of the money paid in license fees is not used for the humane department, but rather is put into the city general fund and is expended for purposes which have nothing to do with small animal regulation.

James Lindsey, executive head of the Tailwagger Association, an association of dog owners and dog lovers, cited figures to show how much of the annual dog license money is being diverted from humane department purposes.

In 1937, Lindsey pointed out, 83,624 dogs were licensed in Los Angeles city. The fees from these licenses plus smaller amounts realized from kennel license charges and pound fees, brought the receipts for the year to $213,240.

Put in General Fund

However, only $98,771 of this amount was put back into the humane department as budgetary expense. The remainder, $114,469, considerably more than half the money collected from dog owners, went into the general fund of the city and was used for general municipal purposes.

Last year was not an exceptional year in this regard. For the past four years the surplus earnings of the humane department have been consistently more than $100,000 a year. During the twenty years of the department's existence, there has been diverted into the city's general fund surplus earnings from the humane department of $1,230,688.

Lindsey and other dog owners contend that if only a reasonable portion of this surplus were spent in an effective humane patrol that would pick up stray dogs and cats and would police the city for sick animals, that the possibility of rabies becoming epidemic would be almost nil.

"But the city does not do this," said Lindsey, "despite the fact that dog owners tax themselves more than $200,000 annually in Los Angeles in the hope of getting such service."

Lindsey pointed out that many dog owners are threatening to discontinue the payment of license fees unless more of the money goes for the purposes intended.

"A Superior Court in San Diego County decided last April that it was unconstitutional to exact a license fee from owners who keep their animals on their own premises at all times," said Lindsey. "A large proportion of Los Angeles dog owners keep their animals continually under such restraint and feel that they would be justified legally in refusing to pay the license under this ruling."—Los Angeles *Times*, April 7.

* * *

Dr. Harold Brunn Named by Surgeons

Election of Dr. Harold Brunn of San Francisco as president of the American Association for Thoracic Surgery at the group's convention in Atlanta, Ga., was reported on April 5 by the Associated Press. He succeeds Dr. Stuart W. Harrington of Rochester, Minn.—San Francisco *Examiner*, April 6, 1938.

* * *

Rabies Fatal

Los Angeles, March 25.—(AP)—Rufus Bradley died today of rabies, the second victim of a mad dog, which bit him a month ago. Stephen Wilson, the first victim, died last week. Seven others bitten by the dog took the Pasteur treatment. Bradley and Wilson did not.—San Francisco *Examiner*, March 26.

* * *

American College of Physicians

New York, April 7.—(AP)—The new president of the American College of Physicians, William J. Kerr, M.D., of San Francisco, took office today and promised forward action on "medical situations arising in the country."

His remarks were taken to refer to the proposal of the association's retiring president, Dr. James H. Means of Boston, last night to organize an opposition party within the American Medical Association and "bring to light leaders" to solve problems of medical care and proposed federal medical aid.—Los Angeles *Examiner*, April 8.

* * *

Aid for Sufferers

Safe Use of Sulfanilamide

Memphis (Tenn.), March 28.—(AP)—Dr. William B. Wendel, University of Tennessee chemist, said today he had developed methylene blue dye as a means of counteracting ill effects of sulfanilamide.

The chemist said that an injection of the blue dye erases one of the most serious toxic effects sulfanilamide produces, as well as providing a simple method of determining when a person is suffering such use of the drug.

Sulfanilamide has been successful in the treatment of throat irritations, erysipelas and mastoid.

"With the development of methylene blue dye as an antidote," Wendel said, "there should be no reason why sulfanilamide should not be administered safely in nearly all cases."—San Francisco *Examiner*, March 29.

* * *

Split in United States Doctor Group Widens

Chicago, April 8.—(AP)—A new attack by Dr. Morris Fishbein, spokesman for the American Medical Association, on the use of federal funds for public medical service, widened the breach today between groups at odds over the question.

Doctor Fishbein said in an address last night that "only the physician is capable of determining the real medical needs of the people."

"Proposals for the use of federal funds in medical service," he said, "are in accord with the extraordinary delusions of grandeur and with the vague and misguided conceptions that continue to emanate from the social service workers who have sought to assume control of the practice of medicine in the United States."

Reply to Statement

Doctor Fishbein replied to Dr. James H. Means, retiring president of the American College of Physicians, who said in a New York address it would be "wholesome" if there was an "enlightened opposition party within the Democracy of the American Medical Association." Doctor Means said he was "not advocating a revolt" against the association.

"Doctor Means," said Doctor Fishbein, "is unfortunately typical of a considerable number of physicians snugly ensconced in laboratories or in full-time positions in medical schools who are unaware of the problems of the general practitioner and who never see the people or even understand those whom they would serve."

Seek U. S. Funds

Their chief objective, Doctor Fishbein continued, was to secure "more and more government funds for the subsidizing of medical education, of hospitals and of the care of the sick." This, he contended, would lead to "confiscatory taxation" of industry and the individual worker "for the benefit of the employees of the bureaucracy and those who have not or will not work."

He said the medical profession has compiled a record in the United States that could challenge that of any state-controlled system in foreign nations. The profession, he added, does not propose to relinquish its functions until satisfied that "some other system will give better medical service to more people."

* * *

Health Plan Action Sought

The California State Supreme Court yesterday was asked to set in operation San Francisco's municipal employees' health insurance plan.

Unable to consider the matter at their conference yesterday, Justices of the Court postponed discussion of the plan until Thursday or Friday.

Asked from the Court, in a petition filed by the Health Service Board, was a writ of mandate directing Controller Harold Boyd to make available to the board all sums deducted from the compensation of members of the health service system.

Court test of the legality of the health plan was forced by Boyd when he refused to turn initial collections over to the board. The plan provides deductions of $2.50 per month from over 11,500 city workers.

Boyd forced the court action because numerous employee groups of the city have assailed the plan.—San Francisco *Examiner*, March 22.

* * *

Cancer Control Month Called

Washington, March 28.—(AP)—The White House made public today a proclamation by President Roosevelt proclaiming April as cancer control month and urging support for a national program for the control of cancer by education.

The President invited governors of the states and territories to issue similar proclamations.—San Francisco *Examiner*, March 29.

* * *

Los Angeles County Auto Death Toll Reaches 231

Three men were dead today, and a three-year-old boy may die of injuries in traffic accidents that made the figures for the year's death toll to date, read 231 for Los Angeles County.—Los Angeles *Evening News*, April 7.

Five Hundred Thousand Are Victims of Daily Injuries

Ten Million Accidents Each Year in U. S.

Washington, April 2.—Ten million accidents serious enough to disable their victims one day or longer occur annually in the United States.

Each day 500,000 persons are unable to work, go to school or pursue their usual activities as the result of injuries caused by accidents resulting from multiple sources, the Public Health Service announced today.

The service disclosed that 7 per cent of the deaths among the 70,000 families canvassed were the result of accidental injury. Accidental deaths were exceeded only by mortalities from disease of the heart, cancer and pneumonia.

It was revealed that sixteen of every 1,000 persons are disabled for a week or longer by injuries each year. The average period of disability experienced by the victims of serious accidents is forty-six days. This is compared with the average duration of disability from all causes, which is fifty-seven days. Automobile accidents average fifty-five days of disability.

Many Are Maimed

Maiming injuries occur most frequently in the course of work, the report states, since 70 per cent of the lost fingers and 46 per cent of the loss of other members are are attributed to occupational casualties. For impaired members, however, home accidents are of equal importance to industrial mishaps.

The home is far from being the safest place, as it is usually considered. More than 30 per cent of all accidents occur there. The home injuries result mainly from falls, burns and cuts.

Boys and men are more liable to suffer accidental injury than are girls and women until the age group above 65 years is reached. The situation is then reversed.

The greatest single source of accidental injury is the fall, which is credited with 39 per cent of all the serious disabling factors. Falls are even a greater menace at present than automobiles, which are responsible for 20 per cent of the nation's yearly accident toll.

Autos Are Deadly

However, the automobile is responsible for the greatest number of accidental fatalities. Persons injured in an automobile are two and one-half times as likely to die as persons injured by any other means.

The report associates the higher rate of accidents in the homes of the very poor with inadequate housing facilities. Faulty stairways, poor lighting and heating conditions and rickety furniture are all factors which are responsible for the excessive home injuries among the lower third income group.

The National Health Survey is attempting a solution of the nation's ever-increasing accident problem by endeavoring to ascertain the source and circumstances under which serious mishaps occur. In this way they hope to suggest preventive measures for each type of accident.—San Francisco *Examiner*, April 3.

LETTERS

Concerning a recent malpractice suit.

STATE OF CALIFORNIA
DEPARTMENT OF INSTITUTIONS
MENDOCINO STATE HOSPITAL

Talmage, California,
March, 29, 1938.

To the Secretary:—I am just in receipt of a telephone message from Mr. Hartley Peart stating that the case of Sarah Florence vs. Doctors Toner, Beardslee, Reilly, Sheehy, Tillman, Cushman, and Mr. Charles Waymire, had been dismissed by order of Judge Michael Roche of the Federal Court in San Francisco. As you know, this suit for one million dollars was brought about three years since, and has been continued from time to time, has been stubbornly fought by the attorney for the plaintiff, Miss ———; but in spite of this strenuous effort on the part of the plaintiff and her attorney, it has now been terminated by the above-mentioned dismissal of the case.

I feel that this case was won only by the earnest, persistent, intelligent and painstaking effort of Mr. Hartley Peart, the attorney for the Medical Society of the State of California, and his associates, Messrs. Gus L. Baraty and Howard Hassard. I wish to express to you my heartfelt appreciation for the faithful service rendered by that society. I had, also, the assistance of Mr. Kilkenny, Deputy

from the Attorney-General's office, who was protecting the State's rights in the matter. However, my individual protection was especially provided by the efforts of the Medical Society of the State of California.

You, perhaps, are aware of the fact that after this suit was filed against us, the ——— Company refused further continuation of protection under that policy which I had carried with that company for several years, on the grounds that the policy did not cover the points at issue.

I feel that if the members of the Association knew more of the dangers of medical practice that they would not hesitate to join the Medical Society of the State of California and pay its small annual charge.

Very sincerely,

R. A. Cushman, M.D.,
Medical Superintendent.

Concerning articles on the Los Angeles County General Hospital.

(copy)

The Queen's Hospital

Honolulu, T. H.,
March 18, 1938.

To the Editor:—Today I received a copy of the February issue of California and Western Medicine, for which I sent an order with stamps to cover to the publication office in San Francisco a couple of weeks ago. I had read in the Los Angeles *Times* a front-page news article about your editorial and comments on the charging and billing innovations at the Los Angeles County General Hospital and felt keenly interested in the subject.

For the past two hours I have been occupied with the reading of the editorial article, the exhibits and comments. Not a word escaped my attention, so completely was my interest engrossed. I congratulate you upon the manner in which you have handled the whole matter. It is typical of your forceful and effective way of dealing with medical-administrative dilettanteism and confusion whether it be in the realm of ethics or economics. More power to you in this crusade!

I take pleasure in sending you, under separate cover, a copy of the Seventy-eighth Annual Report of The Queen's Hospital, just published. I recall your often expressed desire for a printed report from the Los Angeles County General Hospital. It is no credit to Los Angeles County that they continue to neglect so elemental an obligation to the doctors who perform the medical services in the hospital as well as to the taxpayers who support it, not to mention the universally accepted reciprocal obligations between important hospitals to exchange reports on their experiences. The Queen's Hospital of Honolulu has not missed publishing its annual report for many decades, not even during the worst depression years.

My work here has been pleasant, well received and fruitful of results. I look forward to many years of productive activity in my present position despite my advancing years. I feel as young as ten years ago. The marvelous climate of these islands is exceedingly favorable for my health. . . .

P. O. Box 614.

Very sincerely yours,

(Signed): G. W. Olsen.*

Concerning the May meeting of the American Neisserian Medical Society.

March 16, 1938.

Dear Doctor:

The fourth annual session of the American Neisserian Medical Society will be held in Washington, D. C., on May 16 and 17, 1938, in the Public Health Auditorium located at Nineteenth Street and Constitution Avenue, N. W.

The session will open with a symposium on sulfanilamid, which will be timely and of great value to everyone. Perrin H. Long, M. D., of the Johns Hopkins Hospital will deliver the principal address. Doctor Long's work puts him in the position of being the country's leading authority on the chemistry, mode of action, and clinical use of sulfanilamid.

Following the presidential address there will be simultaneous meetings of the three following sections: Male Clinical, Female Clinical, Laboratory and Research. The Male Clinical Section will discuss in considerable detail the question of nomenclature, standard record forms, diagnosis, and cure. The Female Clinical Section will discuss diagnosis and cure. The Laboratory and Research Section will discuss bacteriology, serology, and research. The reports of these deliberations as accepted on the following day will become the Society's official opinion and will serve as authoritative information which, when disseminated, will undoubtedly result in clarifying some of the present needless confusion. This would seem to be an important next step toward improving the management and control of gonorrhea.

For further information, address the Office of the Secretary, 113 Bay State Road, Boston, Massachusetts.

Oscar F. Cox, M. D.,
Secretary.

Concerning venereal disease program of the State Board of Public Health.

State of California
Department of Public Health
Sacramento

San Francisco,
March 23, 1938.

To the Secretary:—Your letter of March 17 addressed to Dr. Howard Morrow has been referred to our office.

This is to advise you that within the next ten days copies of the enclosed letter to physicians will be mailed to all registered physicians in the State. This should clear up any question with reference to the drug distribution program.

We are not in a position as yet to directly subsidize physicians for the care of indigent patients. In the larger centers of population, clinics are available for the care of such cases. Within the next few months it is anticipated that we shall be able to extend our program so that patients in rural districts can be given care. Meanwhile we are furnishing drugs for the treatment of these cases, and in each instance attempting to get the physician to make some arrangement for the patients so that they may be kept under treatment.

If you feel that an article should be prepared for California and Western Medicine with reference to the drug distribution program, may we hear from you to that effect.

Very truly yours,

Malcolm H. Merrill, M.D.,
Chief, Bureau of Venereal Diseases.

* * *

State of California
Department of Public Health
Sacramento

BOARD OF PUBLIC HEALTH
Howard Morrow, M. D., *President*
San Francisco
Edward M. Pallette, M. D., *V.-Pres.*
Los Angeles
W. R. P. Clark, M. D.
San Francisco
George H. Kress, M. D.
Los Angeles
Gustave Wilson, M. D.
Sacramento
Roy A. Terry, M. D.
Long Beach

BUREAU OF VENEREAL DISEASES
Malcolm H. Merrill, M. D.
Chief
State Building
San Francisco, California

Walter M. Dickie, M. D., *Director*

Letter No. 3

To the Physicians of California:

The venereal disease control program has progressed to the point where the third objective can now be announced. A restatement of the first two objectives with the addition of the third is as follows:

1. Every case of venereal disease to be reported.

* Mr. G. W. Olsen was formerly superintendent of the California Hospital at Los Angeles, and later, as assistant superintendent of the Los Angeles County General Hospital, the twelve-million-dollar acute unit building was largely placed in usable form under his supervision. In a shift of officers, his work was not recognized. At that time, upon recommendation of Doctor MacEachern of the American College of Surgeons, he received the offer of the superintendency of The Queen's Hospital in Honolulu, where, we have been informed from other sources, his services have given great satisfaction.—Editor.

2. Every case of venereal disease to have a complete epidemiological investigation.

3. Every case of venereal disease to be kept under the care of a physician until the disease has been arrested or cured.

Studies of the Coöperative Clinical Group have shown from 60 to 80 per cent of clinic patients with syphilis discontinue treatment prematurely. While no statistics are available concerning private patients, indications are that the situation is comparable. The early cases that are lapsing from treatment now will fill our clinics and institutions in years to come. Many will become sources of infection for others as a result of infectious relapse. Adequate treatment for every case of syphilis is the basis of all control measures for this disease. It eliminates foci of infection and prevents the development of late complications.

Why do patients lapse from treatment? This problem was studied some years ago in the Syphilis Clinic of the University of Pennsylvania Hospital. Reasons most frequently mentioned were: painful reactions to treatment; clinic hours interfere with work; financial inability to continue; did not realize the seriousness of the disease; thought themselves cured.

How are we to prevent such lapses? We offer you the following suggestions and specific aids that should assist you in keeping your cases under treatment.

1. The proper instruction of the patient is of paramount importance. It must include convincing evidence of the correctness of diagnosis, outline of treatment to be given, necessity for continuing treatment, some explanation of the interpretation of serological reactions, and possibilities of reactions to treatment. The patient should be told that symptoms will rapidly disappear but ultimate cure requires prolonged treatment. To be really effective this instruction must be given as soon as the diagnosis is made.

2. Frequently the physician's instructions can be fortified by literature for the patient. We have already forwarded to you a copy of our pamphlet entitled *Combating Syphilis*. A companion pamphlet, entitled *Combating Gonorrhea*, is enclosed. A copy of one of these pamphlets will be mailed to you by your local health officer upon receipt of each report of a case of syphilis or gonorrhea. Additional copies can be obtained upon request, from your local health officer or from this Bureau.

3. Probably the most frequent cause of lapse from treatment in private practice is financial inability to continue. During the first interview after diagnosis is made, the financial problem should be discussed fully. Patients should be advised to consider their problem frankly and to depend upon their physicians to arrange for their continued treatment in a clinic if they are unable to continue under private medical care. As physicians we must face this problem realistically if these lapses from treatment are to be prevented. In an effort to relieve part of the financial strain, the State Department of Public Health is now prepared to issue through local health officers a limited supply of antisyphilitic drugs to private physicians for the treatment of indigent and marginal cases. A requisition form is enclosed. A limit of ten ampoules of an arsenical and twelve ampoules of bismuth salicylate (or, if more than one patient, one 60 cc. bottle) will be issued at one time for each patient. Additional drugs can be obtained for any case as the first supply is exhausted. Cases must have been reported before drugs will be issued.

4. Practically all full-time health departments are now equipped to assist you in returning lapsed cases to treatment. Ask for their assistance. The Venereal Disease Act passed by the 1937 session of the State Legislature imposes upon you the legal obligation to keep your patients under treatment, or report the patient by name to the health department. It also gives health officers adequate power to assist you. A copy of this law and State Board of Public Health rulings will be forwarded to you upon request.

5. Enclosed also is a letter from Dr. Thomas Parran regarding the United States Public Health Service periodical entitled *Venereal Disease Information*. This would be a valuable addition to your library.

MALCOLM H. MERRILL, M.D.,
Assistant Acting Surgeon, United States Public Health Service.

Approved:

WALTER M. DICKIE, M.D.
Field Agent, U. S. P. H. S.
Coöperating with United States Public Health Service.

Concerning June 17 and 18 meeting of the American Academy of Tuberculosis Physicians.

Auberry, April 10, 1938.

To the Secretary:—The scientific program of the American Academy of Tuberculosis Physicians to be held in the Hotel Mark Hopkins, San Francisco, June 17 and 18, is almost complete.

Among the speakers are men nationally and internationally known in their particular field of medicine. For this reason, the Program Committee desires to give the medical profession of California an opportunity to hear some or all of these papers.

With this in mind, we are writing to request that you contact the proper authorities with the view of having the program published in the May issue of CALIFORNIA AND WESTERN MEDICINE.

Thanking you in advance for whatever you may be able to do in this, I am

Cordially yours,
EVERETT MORRIS,
Chairman, Program Committee.

Concerning California laws on "disability insurance contracts."

DEPARTMENT OF PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

Sacramento, California,
April 4, 1938.

To the Editor:—Enclosed please find copy of Attorney-General's Opinion No. NS900 addressed to Honorable Samuel L. Carpenter, Jr., Insurance Commissioner of the State of California, in relation to the First National Protective Association of Los Angeles, which we thought might be of interest to readers of CALIFORNIA AND WESTERN MEDICINE in connection with the study of the so-called hospital associations.

420 State Office Building.

C. B. PINKHAM, M.D.,
Secretary-Treasurer.

* * *

(COPY)

San Francisco, March 23, 1938.

Hon. Samuel L. Carpenter, Jr.,
Insurance Commissioner,
417 Montgomery Street,
San Francisco, California.

Dear Sir:

I have your letter of January 6, 1938, relative to First National Protective Association of Los Angeles in which letter you enclose the following documents:

1. Pink card entitled "Now in Effect";
2. Business reply card;
3. Application blank;
4. Certificate;
5. Memorandum from Mr. Risbrough dated December 20, 1937;
6. Memorandum to Mr. Risbrough dated December 29, 1937;
7. Memorandum from Mr. Risbrough dated January 3, 1937.

You state that the definition of "disability" insurance, Section 106, Insurance Code, is essentially the same as the definition of accident and sickness or health insurance contained in Subdivision 6 of old Section 594 of the Political Code, as amended in 1933, which section has since been repealed. The term "accident and health insurance" was the subject of my Opinion No. 9055.

You ask my opinion as to whether the contract issued by the National Protective Association constitutes a contract of insurance which may only be written by licensed companies and whether the contract violates other provisions of law.

The contract in question in substance provides that the member is entitled to all the rights and privileges of the Association as provided in the by-laws and the provisions contained in the certificate.

In the general provisions of the certificate the following services are enumerated: medical service at office of corporation or at home of member; minor surgical operations, treatment of eye, ear, nose, and throat; maternity cases; major surgery; hospitalization; x-rays, and ambulance. The services enumerated are practically the same as those which were mentioned and described in Opinion No. 9055, rendered to the then Insurance Commissioner, under date of December 3, 1938.

I am of the opinion that said contract constitutes a contract of disability insurance and may only be written by a duly licensed insurance company authorized to write disability insurance.

It further violates the principle of a corporation engaging in the practice of medicine expressly denounced in the case of *Pacific Employers Ins. Co.* vs. *Carpenter,* 10 Cal. App. (2d) 592.

The documents submitted with your request are herewith returned.

Very truly yours,

U. S. Webb, *Attorney-General.*

Concerning quarantine order in Los Angeles City.

State of California
Department of Public Health
Sacramento

Howard Morrow, M. D.
President
Edward M. Pallette, M. D.
Vice-President
Walter M. Dickie, M. D.
Director of Public Health

George H. Kress, M. D.
Gustave Wilson, M. D.
Roy A. Terry, M. D.
William R. P. Clark, M. D.

State Quarantine Order for Los Angeles City—Rabies

An investigation having been made as required in Chapter 369, Statutes of 1913, of the State of California, and rabies having been found to exist among dogs living within the City of Los Angeles, the California State Board of Public Health, in accordance with the provisions of Chapter 369, Statutes of 1913, hereby declares a quarantine against all dogs on those portions of property within the city boundaries of Los Angeles, as shown on map, entitled "Map of the City of Los Angeles, California, prepared by Lloyd Aldrich, City Engineer," obtained from the City Engineer's office, March, 1938.

Quarantine under this Act* means the strict confinement, upon the private premises of the owners, under restraint by leash or within properly constructed enclosure, of all dogs within the above described area.

It shall be the duty of all peace officers, all deputies of the City Health Officer, as well as the City Health Officer, to enforce the provisions of this order within the above quarantined area.

The City Health Officer, or other properly constituted officials, may make inspection or examination and enter upon all private premises for the enforcement of this quarantine.

Any owner, or other person, in possession of any animal then being held or maintained in violation of this quarantine, shall be subject to arrest on the charge of committing a misdemeanor.

W. M. Dickie,
Executive Officer, California State Board of Public Health.

Issued by the State Board of Public Health in regular session, March 26, 1938.

* * *

(copy)

Modification of Order Issued March 26, 1938, Declaring a Quarantine against All Dogs within the Boundaries of the City of Los Angeles

Having received from George Parrish, M.D., Health Officer of the City of Los Angeles, a request for the modification of the order issued March 26, 1938, declaring a quarantine against all dogs within the boundaries of the City of Los Angeles, the California State Board of Public Health having made an investigation in accordance with the provisions of Section 2, Chapter 369, Statutes of 1913, hereby modifies the above mentioned quarantine order as follows:

Quarantine shall be defined as the confinement of all dogs within the designated area upon the private premises of the owners under restraint by leash or within properly constructed enclosure, except that persons over the age of fifteen years shall be permitted to take their dogs on the public streets and highways when such animals are controlled by suitable leash not over six feet in length, and when so controlled may also take them on the highway in automobiles but not in any bus, or other public conveyance; except, that those dogs quarantined as rabies contacts and confined to their premises or such other place as may be designated by the health officer, or his representative, shall not be permitted to leave the designated premises upon which they are confined.

W. M. Dickie,
Executive Officer, California State Board of Public Health.

Issued by the State Board of Public Health in regular session, March 26, 1938.

Concerning Clinical Notes paper by Dr. Fred Baker of San Diego, which appears in this issue on page 356.

Point Loma, California,
February 17, 1938.

To the Editor:—I do not know how good your memory of us old codgers out in the sticks may be, but I remember you rather intimately when I was a more active youngster.

I have just passed my eighty-fourth birthday and cannot have many years ahead. I have long had in mind writing of my personal experiences with iodid of potassium during my thirty-odd years of active practice, with notes on one case which I have been able to observe for over forty years. I do not know how far I may have been preceded in my conclusions, as I have not kept up my medical reading for a good many years; but I do know that there are a good many physicians who still prescribe set doses of iodid of potassium, which calls for carefully studied dosage in each case.

It so happens that about thirty years ago I nearly killed myself with overdosage with this drug, and have suffered ever since from a moderate hyperthyroidism combined with a most troublesome tremor and more or less heart disturbance. I want to report this case, as well as personal observations carried on through many years, with some suggestions that, so far as I know, have never been published.

A rough draft of the paper covers only four and a quarter pages of typewriting, spaced, so it will not take up a great deal of space. What I wish to know before working it up more carefully is whether you would probably care to publish such a paper, if I send it in? Of course, you cannot adjudge it properly till you see it, but if such a paper seems likely to meet your approval, I will prepare it and send it to you within a short time after receiving your answer. I am enclosing an addressed postal on which you can send only a line, thus saving the time of a very busy man.

Sincerely and fraternally yours,

Fred Baker.

842 Rosecrans Boulevard.

* * *

Point Loma, California,
February 27, 1938.

Dear Doctor Kress:

Your very kind letter came in this morning and, as I had a rough draft of my paper drawn, I sat down this afternoon and made the enclosed copy, which you can use if it seems worth while. I have not given it a title, but will leave that to you.

I hope you and your readers will pardon the personal element. My case seemed of great importance, especially if the condition has not been emphasized of late. The report may save somebody a lot of trouble if the condition reported is not well known. It has made me a semi-invalid for these thirty or more years, and I came very near dying of heart failure during my two months in bed. Today I am handicapped badly by a very shaky hand, especially as I am devoting most of my time to conchology and use a microscope a great deal. My heart has settled down into a very good heart, which will probably last as long as I do.

For years I have had this paper in mind, feeling that the warning in it should be sounded unless someone else had already done it, but I never got to it. Now it is off my chest and I feel better.

I developed cataract several years ago and had a fine operation, giving me normal vision and a strong eye, which

* California law makes it mandatory upon the State Board of Public Health to declare the quarantine in this form. It is provided, however, that the State Board of Health may modify subsequently, as in its judgment is deemed best.

I work ten or twelve hours a day if needed. I am not strong, but have few important weaknesses. Doctor Charlotte* was in bed for six years and a half, and I took practically all care of her. As it meant night and day work, I was badly used up when she left us. She had severe angina and my consultants give me credit for prolonging her life for several years by being on hand to handle each attack. Two or three times she rallied and we started to teach her to walk again, but each time she fell back very soon. She was cheery to the end, though a great sufferer, and passed quietly in her sleep. It has left me a very lonely old man, but I keep actively at work to forget.

You may not know it, but my hobby for nearly fifty years has been conchology, and it has brought me much wider acquaintance and reputation than ever medicine did. I have published about twenty papers on various subjects and have been in touch with conchologists practically all over the world through exchanging of shells. I have the largest private collection of shells on this coast, I think. If Doctor Charlotte could have kept well through the years, I would have had a most satisfactory existence. As it is I have splendid memories of a most eventful life and a most happy one till the last few years, so why worry. Shall be mighty glad to see you if ever the opportunity comes.

Very sincerely yours,
FRED BAKER.

842 Rosecrans Boulevard.

P. S.—Should have added that in my report the retinitis case was my son. He is husky and has strong eyes, with perfect vision. I have another patient who comes to me occasionally, whom I saw first forty-six years ago. Going some.

MEDICAL JURISPRUDENCE †

By HARTLEY F. PEART, ESQ.
San Francisco

Provisions of the California Insurance Code Relating to So-called "Medical and Hospital" Insurance and to Hospital Service Plans

The Insurance Code adopted by the Legislature in 1935 is a codification of the California statutes relating to the business of insurance. Except for those sections of the California Constitution which concern insurance, all of the laws governing insurance in this State are now to be found in the Insurance Code.

The Insurance Code divides all insurance into twenty classes of which the most familiar are life, fire, surety, disability, liability, workmen's compensation and automobile. All types of insurance done in this State must fall within one of the twenty enumerated classes. For example, "malpractice" insurance falls within the class known as "liability" insurance. "Health and accident" insurance is within the class termed "disability" insurance. So-called "medical and hospital" insurance, which is full or partial idnemnification for payments made by the insured to his own physician for medical care or for payments made for hospital facilities, likewise falls within the disability insurance classification. Hence, this discussion will be limited to a brief consideration of those provisions of the Insurance Code which govern the conduct of the business of disability insurance.

Part II of Division 2 of the Insurance Code is entitled "Life and Disability Insurance" and consists of thirteen chapters, each dealing with some phase of life insurance or disability insurance or both. Chapter 1 of Division 2, Part II, contains certain requirements with respect to life and disability insurance contracts. Chapter 2 relates solely to group life insurance. Chapter 3 governs burial contracts; Chapter 4 contains the various statutory requirements, known as "standard provisions," which must be contained in all disability insurance policies.

One section contained in Chapter 4 requires that all disability insurance policies must be approved as to form by the Insurance Commissioner prior to issuance or delivery to any person. Other sections require that disability insurance policies must express on their face the entire consideration therefor, the times at which the insurance takes effect and terminates, the number of persons insured, and must not contain exceptions printed in smaller type than the benefits to which they apply. Chapter 4 also contains compulsory standard provisions for disability policies which are deemed to be incorporated in the insurance contract whether or not they appear therein. Optional standard provisions are also set forth which may or may not be included by the insurer.

Chapter 5 contains general regulations governing life insurance only, and Chapter 6 provides for incorporated life insurers issuing policies on a reserve basis.

Chapter 7 governs mutual life and disability insurers. Under this chapter a corporation having a capital stock of not less than $200,000 fully paid in and a guaranty fund of not less than $250,000 may qualify as a mutual life and disability insurer and issue life insurance contracts or various forms of disability insurance policies. This would include, of course, contracts indemnifying against loss for the cost of medical care or hospital services.

Chapter 8 governs life insurance upon the mutual benefit assessment plan and contains a provision forbidding the entrance of new associations into this field after January 1, 1936. Mutual benefit assessment associations flourished some years ago, but experience proved that the tendency of these associations was to dwindle in membership as members died and thus to penalize those who lived the longest and paid the greatest number of assessments. The Legislature evidently felt that it was a type of insurance which should not be continued.

Chapter 9 is entitled "Mutual Life and Disability Insurance on the Stipulated Premium Plan, with Provision for Assessments." Briefly, this means that a corporation may engage in the business of issuing life and disability insurance policies which combine two different insurance concepts: one, the collection of necessary reserves by means of periodic premiums in a stipulated amount, and the other, the accumulation of necessary funds by means of assessment of policyholders as the need arises. A corporation engaging in life and disability insurance under Chapter 9 must provide in its insurance policies for periodic premiums payable monthly, and, in addition, must provide for the payment by policyholders of additional premiums or assessments "to the extent needed to pay for their share of claims and expenses and to maintain the tabular reserves required . . ." (Insurance Code, Sec. 10875.)

In other words, insurance policies issued by insurers doing business under Chapter 9 provide for the collection of additional sums from policyholders in the event that premiums collected and the reserves of the insurer are insufficient to meet claims and expenses without impairment of the minimum reserves required by the Insurance Code.

An insurer organized under Chapter 9 may not issue any policy or certificate until at least one thousand persons have subscribed in writing an agreement for each to be insured therein for a death benefit of not less than $1,000 if life insurance, or for a disability benefit of not less than $5 a week if disability insurance, and until each subscriber has paid one premium or assessment of not less than $5 and the insurer has deposited $25,000 with the Insurance Commissioner (Insurance Code, Sec. 10830.) Thus, it may readily be seen that the reserves required of a Chapter 9 insurer are much less than those required of mutual life and disability insurers.

Chapter 9 also contains a provision under which any insurance company, doing business as a Chapter 9 life and disability insurer, may elect to operate as a "mutual legal reserve insurer." In order to take advantage of this provision, such an insurance company must have a minimum paid-in capital of at least $200,000 to issue life insurance policies and an additional $50,000 to issue disability insurance policies. A Chapter 9 insurance company, by securing a paid-in capital of at least $250,000 and converting itself into a mutual legal reserve insurer, may thereby eliminate the assessment provisions of its policies. The Legislature has evidently felt that if an insurance company is to do life and disability insurance business with only a reserve of $25,000, it must have access to additional funds in cases of

* Editor's Note.—See obituary of Dr. Charlotte Johnson Baker, in CALIFORNIA AND WESTERN MEDICINE, March, 1938, on page 203.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

emergency by means of assessments levied upon policyholders, but that if a minimum of $250,000 in paid-in capital is held by an insurance company, it is not necessary to require of policyholders that they be subject to assessment.

Chapter 10 deals with fraternal benefit societies, and Chapter 10 (a) governs firemen's, policemen's, or peace officers' benefit and relief associations. Chapter 11 contains provisions authorizing a change by assessment plan insurers to reserve plan insurers. A minimum paid-in capital of $200,000 is required.

Chapter 11 (a), which was adopted in 1937, is entitled "Nonprofit Hospital Service Plans." Under this chapter nonprofit corporations may issue policies of insurance whereby policyholders are entitled, in the event of illness or accident, to "hospital services." Hospital services are defined as including any or all of the following services: Maintenance and care in hospital, nursing care, drugs, medicines, physiotherapy, transportation, material appliances and their upkeep. (Insurance Code, Sec. 11493.)

Before a nonprofit corporation may qualify under Chapter 11 (a), it must secure a certificate of approval from the State Department of Public Health and, in addition, must secure a certificate of authority from the Insurance Commissioner. The chapter contains provisions with respect to minimum reserve funds and requires that all hospital service insurance contracts must comply as to form with certain enumerated requirements. One of these is that such contracts for hospital service must contain in black-faced type not less than ten point the following:

"Nothing in this contract contained shall in any way or manner restrict or interfere with the right of the subscriber to select the contracting hospital or to make a free choice of his attending physician, who shall be the holder of a valid and unrevoked physicians and surgeons' certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital, in which said hospital services are to be provided and rendered." (Insurance Code, Sec. 11512.)

Chapter 12 governs grants and annuities societies. Chapter 13 relates to voluntary mutualization of incorporated life, and life and disability insurers having a capital stock and issuing non-assessable policies on a reserve basis. In order that an insurance company may take advantage of the provisions of Chapter 13, it must have a minimum paid-in capital of at least $200,000 for life insurance and $50,000 for disability insurance. If it intends to issue both life and disability policies (it cannot issue disability policies alone), it must have a minimum paid-in capital of $250,000.

SPECIAL ARTICLES

CONGRESSMAN SCOTT AND THE A. M. A. RESOLUTION*

The *Bulletin of the San Diego County Medical Society*, in its issue of April 15, 1938, printed the following:

The Washington, D. C., newspaper *Labor*, under date of April 5, 1938, offered "Probe of 'Doctors' Trust' Urged as Health Safeguard" as a special tid-bit to its readers.

The Bulletin voices but two remarks: (1) Please note that San Diego is on the map—for better or worse. (2) That California "Demos" Scott and Voorhis led the attack. Here it is verbatim!

* * *

Congressman Scott Declares "Odious Monopoly" Is Striking at Coöperatives Over Bodies of Suffering Members; Persecution Nation-Wide; Likened to Racketeering.

Forty workers suffering severe illnesses requiring operations are denied treatment in Washington hospitals because they are members of the Group Health Association, a coöperative organization maintained by government employees.

The hospitals are willing to make facilities available, but are restrained by fear of a boycott by the Washington Medical Society.

These disclosures were made in the House this week by Congressman Byron N. Scott (Democrat, California) in an appeal for adoption of his resolution calling for a congressional investigation of the "Doctors' Trust." Scott's demand was seconded by Congressman Jerry Voorhis (Democrat, California).

Unless Congress exposes and scotches "this odious monopoly," Scott declared, sufferers who can be saved by quick surgical attention may go to their graves, martyrs to "inhuman greed."

The California lawmaker declared that several persons whose lives were hanging by a thread were refused admission to hospitals until the Health Association met the exorbitant demands of physicians who are members of the Medical Society.

Because of its low membership fees the coöperative, its officials declare, cannot meet the physicians' charges without going "broke." That is the object of the campaign against the association, the officials charged.

Scott told Congress that, if an investigation is ordered, witnesses will come from all sections of the country with evidence showing that the tactics being employed in Washington are part of a nation-wide crusade by the "Doctors' Trust" against efforts of workers to help themselves.

"Has it come to this," Scott demanded, "that workers are unable to join together in the employment of a group of doctors without experiencing severe limitations in the use of hospital facilities and without incurring the ruthless opposition of doctors who control the medical society?"

It is "high time," Scott emphasized, that members of Congress air "the high-handed attitude of the combine" and let the people understand that "selfish physicians have taken the position they have a vested interest in the sufferings of the people." He added:

"Is it possible that the public, which supports both doctors and hospitals, have no voice in establishing justice and fair dealing?

"Are government and other workers to be subjected to autocratic, domineering, inhuman discrimination because they desire to enjoy the benefits of a coöperative association through which they can obtain medical attention?

"It is an amazing spectacle, in the year 1938, to witness the efforts of a group of physicians here in Washington and in other cities of the United States who are determined to check the course of progress toward a more humane, comprehensive and efficient service in dealing with sickness and the prevention of disease."

What doctors are doing in Washington they have also attempted in scores of other communities, Scott said. He insisted the fight on coöperatives is directed by the American Medical Association, which in turn is dominated by Dr. Morris Fishbein, a bitter foe of every movement to secure medical service for that half of the population which is now going without attention because it is unable to pay doctors' bills.

These specific instances of intimidation and coercion were cited by the California Congressman:

In St. Louis a group of doctors who have been giving fine service to the Wage Earners' Health Association have been notified they will be ousted from the medical society. Here the fight has gone so far that the staff of the Missouri Pacific Railroad Hospital is under attack.

In Milwaukee, outstanding physicians serving a cooperative have been blacklisted by the hospitals after being ousted from the medical society.

Plans of union labor at Akron, Ohio, to form a large health coöperative are being held up by threats of boycotting.

In San Diego, California, doctors who have served a cooperative for five years were suddenly confronted with charges of "unprofessional conduct" and threatened with ouster from the health society.

The Voluntary Health Association of San Francisco, which by city charter provides medical and hospital service for nine thousand municipal workers and their dependents, finds it impossible to get into operation because the medical society has notified the organization committee it would oust any doctor it might employ.

Physicians at Little Rock, Arkansas, who have been engaged in group health work, have resigned from the medical society rather than be kicked out.

Scott recalled that several Washington physicians were subjected to "such bitter abuse and persecution" that they resigned from the coöperative. Doctors who decided to stand by the coöperative have been ousted from the medical society, denied admission to hospitals and are being badgered in other ways.

The situation is not only a national scandal, but it is fraught with the gravest danger to the health and lives of millions of people, Scott contended. A full disclosure, he predicted, would show that many physicians have turned their noble profession into a form of "racketeering."

* See also editorial comment in this issue, on page 306.

LOS ANGELES COUNTY HOSPITAL* (Continued)

CALIFORNIA AND WESTERN MEDICINE, in its issues of February (see pages 73 and 97), March (see pages 156 and 216), and April (see pages 234 and 297), printed articles in which attention was called to certain procedures in vogue in the Los Angeles County General Hospital, as regards admission of patients, billing of indigent patients, follow-up methods in attempting to collect from indigents and near indigents, legal phases and other matters. For the information of those who have been interested in the important principles involved, some press clippings, in which later developments are outlined, are printed below.

* * *

Hospital Probe To Call New Witnesses

Following new attacks by Dr. George H. Kress, President of the Los Angeles County Medical Association, against the system of charging patients at the General Hospital, the County Grand Jury today was planning to call additional witnesses in an investigation of the situation.

Doctor Kress, a member of the staff of the hospital, placed his charges before the jury and in an informal discussion with the jurors asserted that in some cases the hospital charges patients higher fees than the average physician would demand.

He said he believed the hospital should not care for non-indigent patients and that indigents should not be billed for treatment they receive. The medical care given at the hospital, he pointed out, is absolutely free, being donated by 508 physicians and surgeons who give their time and skill so that indigents may not suffer.

In a recent magazine article Doctor Kress cited a case where he said a charity patient at the General Hospital was billed for a $136 operating room fee which, at an exclusive Hollywood hospital would have cost but $12.50. He also declared that the county maintains a collecting bureau which spends more than $100,000 annually sending bills to former General Hospital patients totaling more than $4,000,000, of which only about $300,000 is collected.

It was expected that Rex Thomson, County Superintendent of Charities, would be among the witnesses called by the jury to give the county's side of the matter. Following publication of Doctor Kress's magazine article Thomson declared that under State law the county is compelled to collect the amount of actual cost of service from patients able to pay.—Los Angeles *Evening Herald Express*, April 7.

* * *

Cites County Loss in General Hospital Plan of Billing Indigents

Billing indigent County Hospital patients is unprofitable as well as unethical, Dr. George H. Kress had informed the County Grand Jury today.

A member of the General Hospital medical staff as well as President of the Los Angeles County Medical Association, Doctor Kress was closeted with the jury for more than an hour, making and supporting charges which are expected to lead to an audit of hospital records.

It costs $109,000 a year to bill patients who have received treatment at the hospital, Doctor Kress said, and although $4,000,000 worth of bills were sent out last year, only $300,000 was collected.

Much of this, he added, was from persons unable to afford the high fees charged—fees which, he declared, are often greater than in private hospitals.

"I know of one case where a patient was billed $136 for operating room service which would have cost only $12.50 in the most expensive private hospital in Los Angeles."

Doctor Kress pointed out that the hospital was actually accepting free services from physicians and then attempting to sell them to indigent patients.

"General Hospital is staffed by 508 of the county's best medical men," he said. "They volunteer their services to care for indigents—services worth $2,000,000 a year—and neither ask nor receive fees, but the hospital charges for the work they do."

The Medical Association president suggested that hospital services be confined to those who are indigents or near indigents and that services for indigents should be free, for near indigents at nominal rates.

A test case in Kern County, upheld by the Appellate Court in 1936, held the billing of indigents for county hospital services clearly illegal, Doctor Kress concluded.

The jurors, although announcing no decision, indicated they would question Superintendent of Charities Rex Thomson on the matters touched by Doctor Kress and then probably order an audit of hospital books.—Los Angeles *Evening News*, April 7.

Hospital Fees Protest Aired

Doctor Kress Tells Grand Jury of Asserted Excessive Charges

Cumulative protests against charges assessed against patients at General Hospital were placed before the Grand Jury yesterday by Dr. George H. Kress, a member of the county institution's medical staff.

In an informal discussion with the jury as a whole, Doctor Kress declared that in some instances higher fees were assessed than the average physician charges.

Services Donated

"Moreover, these people receiving treatment at the hospital are supposed to be indigents—supposedly unable to pay even a fraction of regular costs," Doctor Kress said.

The physician then explained that there are 508 doctors who volunteer their services to care for the indigents and that the hospital is charging for duties these doctors perform, but for which they do not ask nor receive a fee.

May Order Audit

Of approximately $4,000,000 in bills sent out for hospital charges each year, about $300,000 is collected, Doctor Kress said. Cost of collecting the bills from indigents and emergency cases runs more than $100,000 annually, he said.

The jury indicated that an audit of hospital records may be ordered.—Los Angeles *Times*, April 7.

* * *

California

(Comments in *Journal of the American Medical Association*, March 19, 1938)

Admission and Collection System Attacked in Charges of County Hospital Graft.—A Grand Jury investigation of the system of admission and collections at the Los Angeles County General Hospital is suggested in an article by Dr. George H. Kress, published in the February issue of CALIFORNIA AND WESTERN MEDICINE. Doctor Kress takes exception to the practice of billing all indigents for hospitalization charges. In addition he terms the amounts charged "stupid and outrageous." He charges that since July 1, 1937, when a new system of admission and collections was introduced at the hospital, the administration has overstepped its bounds in billing all indigents. Prior to July 1, billing was restricted to those hospital patients for whom bills were recommended by the hospital social service department. In answer to an inquiry from Doctor Kress the superintendent of charities stated: "It was felt that it would be more equitable to bill all patients and then arrange payments in accordance with financial ability, rather than bill only a restricted group selected on the basis of immediate financial ability." Charges were made to conform, so far as possible, to the actual cost to the county of providing care, it was said. Under the new system, the client is made aware of his obligation even though there is no immediate prospect of payment. Doctor Kress criticizes this practice and asks the purpose of an elaborate system of bookkeeping to carry accounts which are known in advance to be of no value, in view of the fact that indigent or near indigent are classified as "free" patients. In some instances efforts have been made to force patients to give liens on insurance and property they may have in the future; many patients have been "bombarded" with bills, the letters being almost mandatory in their request for payment, the article asserts. The department of charities, replying to Doctor Kress, denied that the Kern County Hospital Appellate Court opinion, rendered in January, 1936, which declared that county hospitals may hospitalize and care only for indigent or near indigent persons, was used as a basis for claiming reimbursement from a county client. The opinion was considered, however, when the board of supervisors adopted a new schedule of charges for hospital care, based on a cost accounting system, to supersede the old flat rate of $4 per day. In his analysis of the system at the hospital, Doctor Kress uses the total of 56,774 in-patients who received care in the fiscal year 1936–1937. For this group the average number of patient days was 14.7. There are 508 physicians, surgeons and specialists who give their services gratuitously to the institution, the value of which to the group of 56,774 was estimated to be $2,000,000. In contrast, Doctor Kress compares the fund of $2,865,654 collected by the Community Chest from 1,000,000 persons in Los Angeles. For the period 1936–1937 the county received $306,974.02 on accounts for the Los Angeles County Hospital, indicating that the institution received payment from patients while the entire group of professional persons providing the care received not one cent. From July 1 to November 1, 1937, bills amounting to $1,169,921.87 were prepared by the hospital business office; on this basis the total amount of bills sent out for hospitalization to cover the entire year would be $3,509,765.61. About 90 per cent of the statements appear to be "bureaucratic bookkeeping," Doctor Kress

* Concerning Los Angeles County Hospital topics here discussed, see CALIFORNIA AND WESTERN MEDICINE: issues of February, 1938, on pages 73 and 97; March, on pages 156 and 216; and April, on pages 234 and 297.

declares, pointing out that maintenance of the bureau that sends out these notices cost $109,383.09, or 18.7 cents on the dollar collected.

Los Angeles Woman Cleared of Relief Perjury Charge

Tragedy in the form of a broken leg, a major operation, lack of employment, a reportedly broken home and finally arrest, was followed today by a ray of sunshine in the life of Mrs. Blanche Baker, a wheel-chair cripple, when Municipal Judge Newcomb Condee freed her after a preliminary hearing on a charge of perjury.

The woman, who was wheeled into court by her attractive daughter, Joan, twenty, was charged with making an affidavit that she was destitute and without means of support when she applied at the General Hospital last month for a major operation whereas the hospital authorities contended her husband, Albert, was earning $150 a month as a lumber worker and was qualified to support her and pay the bill.

"The hospital could do better than to quibble over a case of this kind where the woman had a broken leg, was ill and destitute," Judge Condee commented as he discharged the complaint.

The husband testified he had been separated from Mrs. Baker for years, did not support her, and that he admitted her into his home ot 1018½ South Vancouver Street after the operation because the daughter, Joan, had brought her there.

Deputy District Attorney John Galliano said he did not concur in Judge Condee's freeing the woman whereupon the jurist offered to wager $5 with him that no judge or jury would convict her.

About one hundred persons in the courtroom applauded when Mrs. Baker was told to go home. — Los Angeles *Herald-Express,* April 11.

Mother in Wheelchair Free in Chiseling Case

"I think it contrary to public policy to quibble over an affidavit made by a woman flat on her back in a hospital and under the influence of sedatives."

That statement from Municipal Judge Newcomb Condee brought cheers and applause from a crowded courtroom when he refused to hold for Superior Court trial Mrs. Blanche Baker, forty-four, brought into court in a wheelchair to be tried as a "charity chiseler."

Arrested and charged with technical perjury the day after she was discharged from General Hospital, Mrs. Baker was accompanied to court today by her twenty year old daughter, Joan Baker.

After calling witnesses to prove the technical charge that Mrs. Baker claimed, while ill in the hospital, that she had no one to support her, when, in truth, her estranged husband had a $150 a month job, Judge Condee dismissed the case.

Judge Condee expressed sharp disapproval of the practice of harassing and worrying sick persons in General Hospital by forcing them to answer questions and sign affidavits when hardly out of the operating room.

Albert Baker testified he had been estranged from his wife and did not support her but did support his daughter.

Mrs. Lee Phifer, 3053 Whittier Boulevard, testified Mrs. Baker came to her on March 5 ill and without funds and she had taken her in. Three days later, she said, Mrs. Baker collapsed with a hemorrhage and the landlady sent her to General Hospital despite Mrs. Baker's desire to go to a private hospital. — Los Angeles *Evening News,* March 11.

PRESS CLIPPINGS: ON MATTERS MEDICAL

Having Relationship to Scientific and Organized Medicine

Private Practice Brings Progress in United States Medicine

Chicago.—(By Science Service).—The United States has made greater progress in providing medical care for its people under the present system than any country that has abandoned that system and the nation should, therefore, hesitate to adopt any system that would give less progress toward good health.

That is the American Medical Association's answer to the report of Miss Josephine Roche, head of the Interdepartmental Committee to Coördinate Health and Welfare Activities of the United States Government. The report was just presented recently to the President. The American Medical Association has commented on it editorially in the *Journal.*

Miss Roche's report, in the opinion of the medical association's editor, says in effect that the answer "to the problem of medical care is sickness insurance and federal or other subsidy or both."

Failure of the authors of the report to mention the positive side of present American accomplishments in the field of medicine and health "gives their report a dismal tone beyond what the situation warrants," the medical association's editor comments. He adds:

"Our progress up to now, which is greater than that in any country that has abandoned our system in behalf of some socialized system of medical care, should cause hesitation in rejecting the pattern of progress that has brought such results, in favor of patterns that have been tried elsewhere with far less success."

Rockefeller Gifts Policy Liberalized

Rockefeller Groups Give Wider Scope for Use of Funds

New York, March 20.—(AP)—The Rockefeller Foundation and the General Education Board today announced adoption of a liberalizing policy to permit recipients of gifts to endowment funds to have wide discretion in their uses.

At the same time the foundation, created by the late John D. Rockefeller, disclosed its appropriations and authorizations in 1937 totaled roughly $5,000,000.

Look to Future

"These liberalizing provisions," said a preliminary report, written by Raymond B. Fosdick, president of the Foundation, "represent an attempt to free the future from frozen funds and 'tired' endowments, in the belief that the wisdom of this generation cannot be substituted for the wisdom of the next in the solution of problems hidden from our eyes.

"The endowments affected by these provisions amount to $51,000,000 given to date by the Rockefeller Foundation, and $148,000,000 given by the General Education Board."

Gifts Total

Rockefeller, who died in his ninety-eighth year on May 23, 1937, gave away about $530,000,000 before his death. He gave a total of $446,000,000 to establish four funds: The Rockefeller Institute for Medical Research, the General Education Board, the Rockefeller Foundation, and the Laura Spellman Rockefeller Memorial. In addition he had made individual contributions of about $84,000,000 for educational, religious, and charitable purposes.

"Specifically," the announcement said, "under a resolution passed by both boards in 1937, notification is sent to each recipient that it is the desire of the boards that the gift, 'whether the income only is spent or the principal as well, shall always be regarded as available for use in the broadest way so as best to promote the general purpose for which it was made.'

Provisions Outlined

"The notification contains the provisions outlined in general terms in the three succeeding paragraphs:

"1. Ten years after the date of the gift, the income from it may be used in whole or in part for some purpose other than that for which the gift was made, such purpose to be as reasonably related to the original purpose as may be found practicable at the time, having regard to intervening changing conditions.

"2. Beginning five years after the date of the gift 5 per cent of the principal of the fund may be used each year for any purpose for which income may then be used.

"3. After the expiration of twenty-five years, any part or the whole of the principal may be used for some other purpose, the new purpose—as in point one—to be as reasonably related to the original purpose as may be found practicable at the time, having regard to intervening changing conditions."

Money Spent

Since the founding of the four funds by Rockefeller, the announcement goes on, a total of $645,000,000 has been spent in eighty-eight different countries.

Explaining the liberalizing move, the announcement says Rockefeller himself "trusted the future."

"He did not think that benevolence and wisdom were confined to his generation. He was not under the illusion that what seems important today will necessarily be important tomorrow."—Los Angeles *Times,* March 21.

General Tax for Medical Care Urged

Federal Subsidy for Schools, Hospitals, and Laboratories Also Sought by United States Society

New York, April 4.—(AP)—General taxation to help pay for medical care and Government subsidy for medical schools, hospitals, and laboratories that "produce" medical

discoveries, were advocated today before the American College of Physicians, one of America's powerful medical societies.

An ideal was declared at issue, for which it was said only Government aid might suffice. This ideal is giving "the highest quality" of medical service, rather than merely "adequate" care.

The proposals were made by John P. Peters, M.D., of Yale University, secretary of the famous "Committee of 430" doctors which last November upset precedent with a declaration in "the lay press" that health is a direct concern of Government.

Health Problems

A breach which this threatened with the American Medical Association was reported healed last month when the association announced it would investigate all aspects of medical care.

Doctor Peters made a distinction between practice of medicine and its "production." Practicing doctors, he maintained, no longer produce much medicine. That is done mostly by "educational and research institutes and hospitals."

But he said practicing physicians offer solutions for health problems that overlook the production side. Meanwhile the medically productive institutions are reduced more and more to philanthropy for their funds.

"It is," said Doctor Peters, "in their complete neglect of the productive aspects of medicine that such measures as health insurance and ordinary coöperative organizations fail to meet the situation."

He declared that "governmental subsidy" is the only sound alternative yet discovered for this situation.—Los Angeles *Examiner*, April 7.

* * *

California Ranks Second in New Deal Cash

Report Shows How $32,000,000,000 Was Distributed in Recovery Drive in Nation

Washington, April 16.—(Exclusive)—A new report on the way nearly $32,000,000,000 worth of Federal cash and credit was distributed in less than five years in the New Deal effort to restore prosperity showed today that seven states have received more than one-third of the benefits from President Roosevelt's relief and recovery program.

The detailed accounting shows California standing second in the list of beneficiaries of New Deal outlays. . . .

California Benefits

Primarily because of the amounts borrowed from miscellaneous Federal agencies under different relief programs, California has received more money and credit from the Federal government than any other state except New York. Other states getting benefits in excess of $1,000,000,000 each are Illinois, Michigan, Ohio, Pennsylvania, and Texas.

From the time President Roosevelt entered the White House until the end of 1937, California received—in loans and grants to individuals, cities, counties, other political bodies and the State government—$1,884,759,607. In contrast, benefits to New York aggregated $3,008,440,820.

Not All Profit

While California stands next to the top among the chief beneficiaries, the State's share of the New Deal outlays is by no means all profit. California is expected to pay back more than any other state except New York. Also, the total includes $237,716,337 worth of Federal Housing Administration insurance on bank, insurance company, building and loan association, and other institutional advances to citizens.

From the standpoint of direct cash grants and expenditures, California ranks fourth, with New York, Pennsylvania, and Illinois receiving more outright benefits from the Federal Treasury.

Types of Aid

Total Federal expenditures credited to California, including eleven different major types of aid, are $866,266,057, against New York's $1,665,434,364.

This sum is broken down as follows:

Agricultural Adjustment Administration crop-curtailment and soil conservation payments, $26,816,242; Farm Security Administration grants, $807,471; Civil Works Administration grants, $38,752,560; Federal Emergency Relief Administration grants, $163,934,678; Civilian Conservation Corps expenses, $125,960,159; Bureau of Public Roads advances, $55,960,159; Social Security benefits, $32,178,990; Public Works Administration grants, $113,523,478; Works Progress Administration grants, $215,160,989; Reclamation Service expenses, $43,505,940; public buildings, $1,950,668; miscellaneous, $47,687,841.

Loan Figures

California has borrowed $780,777,213, the second largest amount of any state.

This is broken down as follows:

From the Reconstruction Finance Corporation, $387,409,766; Farm Credit Administration, $218,912,140; Commodity Credit Corporation, $1,831,161; Farm Security Administration, $4,030,354; Home Owners' Loan Corporation, $136,706,750; Public Works Administration, $23,547,115; Rural Electrification Administration, $1,483,000; Disaster Loan Corporation, $6,300; Federal Reserve Board, $6,850,627.

Besides lending this sum, the Federal government has underwritten $237,716,337 worth of loans made under the Federal housing program. Showing California has played a leading part in this effort to stimulate recovery, the report disclosed residents of the State have borrowed $78,059,815 for repairs and modernization of property and $159,656,522 to finance purchase of homes.—Los Angeles *Times*, April 17.

* * *

Cancer Death Slash Seen

Doctors Expect Reduction of Half

New York, March 25.—(AP)—Fifty per cent of the loss of life from cancer, second largest cause of American deaths, can be stopped with present medical treatments, the American Society for the Control of Cancer was told tonight.

The cut in half was predicted by Ellis Fischel, M.D., Chairman of the Missouri Cancer Commission. Furthermore, he said, Missouri is now going to show the world that this can be done. The annual deaths are 150,000 in the United States.

Backing for Doctor Fischel's record-breaking forecast came from United States Surgeon General Thomas Parran, M.D., speaking to the society by radio from Washington.

The best treatment now available, if used, he said, could save 25,000 lives annually. The potential number that could be saved, he added, would be greatly increased if diagnosis could be made earlier than at present.

The meeting was the twenty-fifth anniversary of the American Society for the Control of Cancer. It laid the blame for much of the loss of life in cancer to fear, ignorance, and public apathy. Cancer as a death cause is second only to heart disease, which takes more than 300,000 lives a year.

Doctor Fischel said that all over the United States cancer kills twice as many as tuberculosis. Nevertheless, only seven states "have taken on themselves any real responsibility." Other states care for feeble-minded, blind and tuberculous, he explained, but not cancer.

Missouri, one of the seven, he said, has sponsored lay cancer education, medical training to recognize cancer, and facilities for diagnosis and treatment.

If, he declared, the agencies fighting cancer fully understand these measures, work harmoniously and "use the knowledge we now possess, we can confidently expect a 50 per cent decrease in the annual death rate from cancer."

James Ewing, M.D., one of the half dozen foremost cancer authorities, proposed seven steps to fight cancer:

1.—Periodical examination.

2.—End of the misconception that cancer is a single disease.

3.—Quiet, scientific rather than emotional study of cancer.

4.—Emphasis that speed of cure differs in various stages.

5.—New ways of approaching the non-reading masses.

6.—More emphasis on prevention.

7.—A readable cancer book for laymen.

A new move to combat cancer, known as the Cured Cancer Club, was recognized at the celebration. Its president, Dr. Anna C. Palmer, who was cured of cancer eighteen years ago, said the club members are persons who have been cured for five or more years.

Their object is to convince the public that fear of cancer is exaggerated, but that vigilance is essential.—San Francisco *Examiner*, March 26.

CALIFORNIA'S CHILDREN LARGER AND TALLER

In the late fifties, Dr. Henry Gibbons, a pioneer physician and first president of the California State Board of Health, stated in a medical journal that babies born in his practice in California were much heavier and longer than those delivered by him when practicing medicine in eastern states.

In 1918, Children's Year, medical examinations of children were made by physicians throughout the country and their findings assembled by the Children's Bureau of Wash-

ington. Weighing and measuring were done carefully and records from all of the states were analyzed by Dr. Robert Woodbury of the Children's Bureau. He found that California infants were taller and heavier than those of other states.

A new study covering children of school age in California has been undertaken by Dr. Orren Lloyd-Jones in Los Angeles. He has found that California school children exceed in stature and weight any available published record of comparable groups elsewhere. His report, published in the bulletin of the Los Angeles Department of Physical Education, reads as follows:

"Many persons who have worked with school children have long believed that the children of California were bigger than those who lived in other parts of the country.

"The question is, do California living conditions stimulate body growth in children to a greater extent than do living conditions in eastern and middle western states? Doctor Lokrantz decided to bring forth evidence that would bear on the matter. Through the agency of the WPA, a massive amount of data has been collected and studied statistically.

"Merely to measure all California school children of a given age and compare them with a comparable group of the East would obscure in a measure any specific California influence. This is because children now in California schools have in large part come here from the East and have been subjected to the out-of-door life and perpetual sunshine of the environment for varying periods. One way to make a critical study would be to measure California native-born children alone, and to compare their average heights, age for age, with the heights of school children as recorded in other cities. Strange to say, there are available but very few published records comprising data of this kind with which we can compare the native-born California children. That is one reason why the whole subject has remained so long in the discussion phase and why a satisfactory 'show down' has been impossible.

"If, in truth, California climate is acting as any special influence on growth, it must be acting constantly though slowly. Its effect should be accumulative year by year as the growing child lives longer and longer in California. We sought for evidence of such cumulative effect, and we have devised a method to measure it. For example: assemble all the fifteen-year-old girls or boys in our schools who have been born outside the state; record for each one the date of coming to California; list these children in columns according to the number of years they have spent in California; in these columns set down the height of each child. We can now derive the average heights for each 'years in California' group. You readily see that we now have figures that will reveal any effect of an environmental influence which has been operating during residence in California. We can now not only compare the heights of the 'five years in California' with the 'ten years in California' group among fifteen-year-olds, but we can also compare each of these figures with the average heights of fifteen-year-olds who have been born in this State.

"Such studies we have made not only on fifteen-year-olds, but on each age from six to seventeen years. Altogether we have records of some 25,000 white children who have been born elsewhere and on some 50,000 white children who have been born in California.

"A detailed and critical analysis of these elaborate statistical tables will be made in a scientific paper in an appropriate place. At this time we are able to state that the average height of children of a given age born elsewhere than California is invariably less than the average height of California native-born children. Now consider the interrelationship of the 'several years in California' groups into which the 'born elsewhere' children have been subdivided as above described. For the fifteen-year-olds, for example, there are three such 'years in California' groups. We find that the shortest children are in general those who have dwelt in California five years or less. Slightly taller is the group who have lived here six to ten years. The tallest of the three groups is the 'eleven to fourteen years.' Yet remember that taller than any of these three groups is the 'born in California' average. And remember that we are dealing with averages and not individuals. It might well turn out to be a fact that the shortest fifteen-year-old in the California schools is a 'native-born Californian's' grandson of a Forty-niner; and that, towering among the tallest fifteen-year-olds is a youth only recently arrived from dingy Pittsburgh. These conditions might obtain without in any way reflecting on the statistical validity of our results.

CONCLUSIONS

"1. In the upper statures and ages of school children there is a definite increase in ratio of height to weight among California children.

"2. Average weight for height in school children of lower statures and ages has not been altered by residence in California.

"3. California school children of every age exceed in stature and weight any available published record of comparable groups elsewhere.

"4. California school children born in this state (*i. e.*, native born) exceed in stature and weight California school children born elsewhere of the same age.

"5. There is a definite positive correlation between length of body and length of stay in California when recorded in 'five-year-periods' within any school age."

"ASSOCIATED HOSPITAL SERVICE OF SOUTHERN CALIFORNIA"†

LESS THAN THREE CENTS A DAY FOR HOSPITAL CARE

When we are well the possibility that later we may have to go to a hospital seems remote. We forget that one family out of five on the average throughout the nation has a hospital case every year. If we knew in advance when we or a member of our family should go to a hospital, we might save enough to pay the bills, but usually there is no way of knowing this.

There is a common-sense way of being constantly prepared for hospital costs. This is the three cents a day plan.

Through this low cost plan, residents of Southern California may assure themselves of excellent hospital care in any one of more than twenty-eight member hospitals.

WHAT THIS PLAN OFFERS YOU

Every subscriber, including family members accepted by the plan, is entitled to any or all of these services when his own doctor says he must go to a hospital:

Hospital care for twenty-one days in one or more admissions each contract year.

Semi-private accommodations (a bed in two-, three-, or four-bed room).

General nursing care.

Meals and services of dietitian.

Routine medications and dressings.

Casts, splints, intravenous medications.

Surgery supplies and medications.

Use of operating rooms.

Use of cystoscopic rooms.

Use of labor and birth rooms and care of mother and baby for twelve days (after waiting period and other provisions of subscriber's contract).

Private room upon the payment of the difference between $5 and the daily rate of the room selected. Subscribers selecting a private room are entitled to the above services.

The above listed services will be rendered for any illness or injury except Workmen's Compensation Act cases, tuberculosis, quarantinable disease, mental disorder or alcoholism (as outlined in subscriber's contract).

SERVICES NOT INCLUDED

Services rendered by your physician or surgeon and his consultants or medical specialists and special private nurses are excluded.

The plan does not include services for conditions resulting from pregnancy during the first year of enrollment.

Out-patient services are not included.

† This is the first corporation to start operations in California under the Nonprofit Hospitalization Law enacted by the last California Legislature (A. B. 1132). See item in CALIFORNIA AND WESTERN MEDICINE, December, 1937, on page 434.

HOW MUCH OF ORDINARY HOSPITAL SERVICES DO YOU RECEIVE IN CASE OF ILLNESS OR ACCIDENT?

You receive practically all of these services without charge; the exception being those services rendered by medical specialists or consultants of your physician while you are in the hospital, such as the services of the physician administering the anesthetic, the roentgenologist and his technicians who make and interpret the x-ray films, the pathologist and his assistants who make and interpret the laboratory examinations. You pay these medical specialists for their services as you pay your attending physician, but you do not pay for the use of x-ray or laboratory rooms.

SAFEGUARDS FOR YOUR PROTECTION

The California State Insurance Commissioner has free access to the books of Associated Hospital Service of Southern California. Rates charged the subscriber are subject to his approval. All contracting hospitals are approved by the State Department of Public Health.

NONPROFIT

Associated Hospital Service of Southern California is a nonprofit corporation organized for the benefit of the community.

VACATIONISTS OR TRAVELERS

In case of accident or emergency illness while on vacation or while traveling outside of this area, benefits will be provided, but the cost of such service will be met only to the extent of payment up to the amount paid to member hospitals.

HOW TO JOIN

It will be noted that applications are accepted only in *groups*.

Enrollment in groups is necessary:

1. Because there is no physical examination of applicants.
2. So that the subscribers will represent a normal cross-section of the community, and the volume of hospital service they require will be no more than occurs annually among any average or normal group of persons.
3. To prevent abuse and to equalize risks.

Applications submitted individually cannot be accepted. Associated Hospital Service of Southern California will not form groups from individually submitted applications.

WHO MAY JOIN

Applicants must be:

1. In good health.
2. Not more than sixty-five years old.
3. Residents of the area served by our member hospitals.

Once a person's application is accepted at the age of sixty-five or less, he may continue as a subscriber.

The application form which every subscriber must sign contains the statement that he or she understands that the benefits of the plan do not apply if a definite need for hospital care is known at the time application is made.

A NONPROFIT SERVICE

This three cents a day community service is operated by the Associated Hospital Service of Southern California, a nonprofit corporation, organized under the provisions of a special act of the California State Legislature.

WHEN SUBSCRIBER GETS SERVICE

Accident or emergency illness: Immediately after your application has been accepted.

Other illness or injury: Immediately after your application has been accepted.

Hospital maternity care: Any time after husband and wife have been members for one year.

You receive service as soon as your physician decides that you need bed care in a hospital.

WHAT THIS COSTS YOU

Rates have been so established that the plan will operate on a self-sustaining basis. The plan does not depend on new enrollments to provide financial soundness.

Subscription charges are as follows:

1. Individual subscription, where 60 per cent of employees in a group are men.

Monthly	Quarterly	Semiannually	Annually
$.75	$2.60	$ 5.00	$ 9.00

2. Individual subscription, other groups than above.

Monthly	Quarterly	Semiannually	Annually
$.85	$2.75	$ 5.30	$10.00

3. Husband and wife.

Monthly	Quarterly	Semiannually	Annually
$1.50	$4.70	$ 9.20	$18.00

4. Husband, wife and all unmarried children under nineteen years of age.

Monthly	Quarterly	Semiannually	Annually
$2.00	$6.00	$12.20	$24.00

Monthly payments are accepted only through payroll deduction. Payments of the individual subscription rates except monthly may be made direct to Associated Hospital Service of Southern California by each subscriber upon written notice. An initial payment must accompany each application unless payroll deduction method is used.

FAMILIES IN PAYROLL GROUP GET LOW RATE

The seven cents a day service for whole families is available only to groups, and is limited to husband and wife, one of whom must be employed by the organization, and to all of their unmarried children under nineteen.

Other members of a family or household may enroll, provided their applications are submitted at the same time by another member of the family or household who is an employed subscriber.

METHOD OF ENROLLMENT

Each subscriber must sign an application form in duplicate made available through the coöperation of the employer for persons employed in organized groups. Others may obtain such application forms direct from Associated Hospital Service of Southern California. Applications must be submitted by employed groups.

Each subscriber will be furnished with a subscriber's certificate setting forth the benefits and conditions of the plan and bearing the date on which the subscription agreement becomes effective.

The subscription agreement with each subscriber covers the period of one year from its effective date, and from year to year thereafter, and does not mean a calendar year. The application of the subscriber and the subscriber's certificate issued as evidence of the acceptance of such application constitute the agreement with the subscriber.

OTHER FACTS YOU SHOULD KNOW ABOUT HOSPITAL PLAN

Size of Organization Where You Work

Less than twenty employees, but not less than five.

In small groups as above 100 per cent of employees must enroll.

Percentage of Group Required

In organizations of twenty or more employees 40 to 60 per cent must enroll, depending upon—

(1) Total number of employees.

(2) Percentage of women in the employed group.

Group Enrollment Only

(1) Individual subscribers are not taken. Everyone must enroll through employed groups.

(2) Members of the family can join only at the time wage earner in family joins.

(3) Monthly payments can be made only through your employer by payroll deduction method.

(4) Direct payments to Associated Hospital Service of Southern California can be made on a quarterly, semiannual or annual basis in advance.

(5) Employees or members of their families wishing to join after a group has been organized can join only under the following provisions:

(*a*) If they are new employees.

(*b*) By physical examination (cost to be paid by applicant).

(*c*) Additions to families.

Range of Costs

From 75 cents per month per individual to $2 a month for husband, wife and children. See schedule above.

Other Family Members

Members of family or household (other than wife or children), may join as individual subscribers by paying $2.75 quarterly; $5.30 semiannually or $10 annually (in advance) direct to Associated Hospital Service of Southern California.

No High Pressure

No agency or salesman is employed to solicit subscriptions on a commission basis.

Hospital Plan Set-Up

A fund is created from the regular and equal payments of subscription charges paid by subscribers, and is used for the sole purpose of paying their hospital bills.

HOW YOU ENTER HOSPITAL

When your doctor says you should go to the hospital, you and your doctor select a hospital where he is privileged to practice from Associated Hospital Service list of hospitals in Southern California. Your doctor will make the usual arrangements for your admission as a patient and when you arrive at the hospital you will give the hospital admitting officer your Associated Hospital Service identification card. There will be no embarrassing questions. You will be admitted without delay.

Only participating member hospitals are authorized to render service under this plan. Other hospitals may render such service only in event of accident or emergency illness occurring to the subscriber when more than fifty miles from a member hospital.

ENDORSEMENTS

Associated Hospital Service is endorsed and approved by the Los Angeles County Medical Association and the California Medical Association. It has the support of many large business organizations in Southern California.

* * *

Sacramento, Calif., March 2, 1938.

R. E. Heerman, President,
Associated Hospital Service of Southern California,
525 Chamber of Commerce Bldg.. Los Angeles.

Have just learned that you are now ready to operate under new legislation Assembly Bill 1,132 for group hospitalization in Southern California. This is a most worthwhile service to the community and I congratulate you on being the first organization in California to operate under this law.

Frank F. Merriam,
Governor of California.

* * *

Los Angeles, March 2, 1938.

Mr. R. E. Heerman, President,
Associated Hospital Service of Southern California,
Los Angeles, California.

Dear Mr. Heerman:

It has come to my attention that the Associated Hospital Service of Southern California, which has been organized in California for group hospitalization, has received its permit to operate on this basis from the California Insurance Commissioner and the Los Angeles Chamber of Commerce wishes to be one of the first to congratulate you and your organization upon this accomplishment.

We believe that such an institution properly handled, as we feel confident yours will be, will go far toward providing those facilities for individuals who in the past have not been able to obtain first-class and efficient hospitalization under competent hospital personnel.

We wish you and your organization every success.

Sincerely yours,
Los Angeles Chamber of Commerce,
W. S. Rosecrans, President.

HOSPITALS OFFERING SERVICE UNDER THREE-CENT PLAN

Inspected and Certified by the State Department of Public Health

Alhambra—Alhambra Hospital.
Compton—Las Campañas Hospital.
Glendale—Physicians and Surgeons Hospital.
Huntington Park—Mission Hospital.
Inglewood—Centinela Hospital.
La Jolla—Scripps Memorial Hospital.
Loma Linda—Loma Linda Sanitarium and Hospital.
Long Beach—Long Beach Community Hospital, Seaside Memorial Hospital.
Los Angeles—The California Hospital; Cedars of Lebanon Hospital; Hospital of the Good Samaritan; Methodist Hospital of Southern California; Presbyterian Hospital, Olmstead Memorial Hospital Lessee, Hollywood Hospital; Santa Fe Hospital; White Memorial Hospital.
Orange—St. Joseph Hospital.
Oxnard—St. John's Hospital.
Pasadena—Collis P. and Howard Huntington Memorial Hospital, St. Luke Hospital.
Redlands—Redlands Community Hospital.
Riverside—Riverside Community Hospital.
San Diego—Mercy Hospital.
San Pedro—San Pedro Hospital.
Santa Barbara—Santa Barbara Cottage Hospital, St. Francis Hospital.
Santa Monica—Santa Monica Hospital.
Torrance—Jared Sidney Torrance Memorial.
Ventura—Foster Memorial Hospital.

* * *

Officers and directors: President, R. E. Heerman; Vice-President, W. H. Kiger, M.D.; Treasurer, Edward M. Pallette, M.D.; Secretary, Leonard K. Brown.

Directors: Right Rev. T. J. O'Dwyer, Philips J. Edson, M.D., J. M. Burlew, M.D., Anna K. Vogler, Glenn E. Myers, M.D., Roland Maxwell, Alice G. Henninger, Harry H. Wilson, M.D.

Executive Director, L. B. Rogers, M.D.*

SYPHILIS, A FORMER "HUSH-HUSH" DISEASE

It has become commonplace to speak of syphilis in public these days. How strange! Only a few years ago it was strictly a hush-hush disease. This is a good sign, for the decks are now cleared for action and the attack may be launched with all its force.

This was true about tuberculosis in the old days. When people stopped whispering "She's got consumption. Isn't it a shame?" and openly declared "She has tuberculosis. It's lucky she found out early," then the great white plague began to fold up its tent.

Surgeon-General Parran recently said he didn't know which was the worst tragedy, an unwanted baby or a syphilitic baby. It is a difficult decision to make, but at least the unwanted child may have a healthy body, while the syphilitic child faces life with a serious physical or mental handicap. Doctors have found that an adult can be cured of acquired syphilis in virtually 100 per cent of the cases if modern treatment is begun early and carried on long enough. But the child with congenital syphilis faces a much more gloomy outlook for the possibility of a cure. Congenital syphilis is much more resistant to treatment, and even at best a much lower percentage of cures can be achieved. However, with treatment, the condition of every child can be improved and destructive processes can be prevented or held in check.

The great tragedy of congenital syphilis is that it doesn't need to occur. More than ninety babies out of one hundred with syphilitic mothers will be born free from syphilis if their mothers begin treatment before the fifth month of pregnancy and keep it up.

The difficulty is that mothers refuse to have the simple test and to take treatment if they are found to have syphilis, and many doctors do not give the test. What can be done? Mothers refuse because they think of a test for syphilis as

* Office is in the Chamber of Commerce Building, 1151 South Broadway, Los Angeles. Telephone, PRospect 2579.

disgraceful. It is to them an insult by the doctor. They forget that much syphilis is acquired innocently. Perhaps they suspect syphilis and may wish to hide it, to their everlasting regret, if their child is born dead or diseased. Doctors too often do not ask their patients to have a test because they do not want to risk "hurt feelings." Seven states have made a stab right at the heart of the problem and now require that all couples present a certificate showing freedom from syphilis before a marriage license is issued. There is one loophole, however, in this procedure. Syphilis may be acquired after marriage but before the children come along. The only safe method of preventing congenital syphilis is to test each pregnant woman as early in pregnancy as possible and at least before the fifth month, and, if she is found to have syphilis, to give continuous treatment until the baby is born.

There is now pending before the New York State Legislature a bill requiring blood tests by law for expectant mothers as a protection against syphilis for them and their babies.* It has the backing of medical, civic, and health groups. If it passes, it should remove whatever stigma there is in the minds of mothers about taking a test for syphilis. Doctors need not apologize for asking their patients to have the test. All they need to say is "The law requires it for every mother."

Would not similar laws in all states be effective in saving thousands of babies from the ravages of congenital syphilis? Those who are interested in this proposed legislation for their states may secure copies of the New York State bill from the Maternity Center Association. "Briefs": Published by the Maternity Center Association, New York City.

CALIFORNIA BIRTHS IN 1937

There were 94,286 births registered in California last year, as compared with 84,460 in 1936, and 80,222 in 1935. The rates per thousand population were 14.4, 13.2, and 12.8 respectively. The 1937 rate of 14.4 is the highest that has been recorded in recent years. There were 14,064 more births registered in 1937 than in 1935. This represents an increase of 17.5 per cent.

While this increase in births is found in almost every community of the State, it is noticeable that in the San Joaquin Valley, where large numbers of migratory laborers have been present during the past two years, the increased number of births is particularly conspicuous. In the larger cities of the State, while the increase is noticeable, the rate of increase is not so great as that for the State as a whole. In San Francisco, Los Angeles, San Diego, Long Beach, Oakland, Sacramento, Pasadena, and Berkeley there were 42,647 births last year as compared with 36,495 in 1935. This represents an increase of 6,152, or 16.8 per cent. In the eight counties of the San Joaquin Valley where migratory laborers have been present in large numbers (San Joaquin, Stanislaus, Merced, Madera, Fresno, Kings, Tulare, and Kern counties), there were 12,402 births registered in 1937 as compared with 9,812 in 1935. This represents an increase of 2,590 or 26.4 per cent in those counties.

Births among members of the white race continued to show an increase in 1937. During that year, the percentage of white births was 82.3 per cent as compared with 80.8 per cent in 1936 and 80.4 per cent in 1935. The proportion of Mexican births was slightly lower in 1937. In that year 12.9 per cent of the total were Mexicans as compared with 14.4 per cent in 1936 and 14.7 per cent in 1935. A similar reduction is noted in Japanese births and a slight increase is noted in the proportion of Negro births. Births among Indian, Chinese, and other races remain at stationary levels. Out of the 94,286 births registered last year, 77,576 were whites, 12,173 Mexican, 1,534 Negro, 1,436 Japanese, 542 Chinese, 436 Indian, 377 Filipino, and 212 of other races.

The following table gives the number of births and the annual birth rate for the counties of California during the years, 1935, 1936, and 1937:

BIRTHS BY COUNTIES

	1937		1936		1935	
	Number	Rate	Number	Rate	Number	Rate
Totals	94,286	14.4	84,460	13.2	80,222	12.8
Alameda	6,939	13.2	5,937	11.5	5,775	11.3
Alpine	2	8.3	...			
Amador	72	8.2	66	7.6	77	8.9
Butte	705	19.8	609	17.2	606	17.2
Calaveras	64	10.6	60	10.0	47	7.8
Colusa	163	15.3	163	15.4	164	15.6
Contra Costa	1,101	12.5	940	10.9	1,011	11.9
Del Norte	71	12.9	53	9.9	73	13.9
Eldorado	140	15.5	151	16.9	106	12.0
Fresno	2,890	19.2	2,570	17.2	2,495	16.8
Glenn	158	14.4	132	12.1	152	13.9
Humboldt	702	15.4	688	15.2	635	14.2
Imperial	1,437	21.3	1,327	20.0	1,349	20.6
Inyo	106	16.2	88	13.4	66	10.1
Kern	2,523	27.1	1,969	21.5	1,645	18.3
Kings	663	24.9	577	21.8	520	19.8
Lake	84	10.7	84	10.9	82	10.7
Lassen	318	22.5	249	17.9	231	16.9
Los Angeles	35,741	13.3	32,027	12.2	30,119	11.8
Madera	484	25.4	322	17.2	275	14.9
Marin	356	7.6	304	6.6	274	6.0
Mariposa	30	8.8	32	9.5	33	9.8
Mendocino	360	15.3	328	14.0	312	13.3
Merced	844	20.4	690	17.0	677	16.9
Modoc	91	10.1	89	10.0	90	10.3
Mono	8	5.3	9	6.1	7	4.8
Monterey	1,038	16.3	936	15.1	907	15.0
Napa	295	12.4	287	12.1	239	10.2
Nevada	286	27.0	246	23.2	225	21.2
Orange	2,052	14.6	1,963	14.3	1,883	14.1
Placer	296	11.1	256	9.7	255	9.8
Plumas	166	18.9	130	15.1	93	10.9
Riverside	1,771	19.1	1,648	18.1	1,619	18.1
Sacramento	2,530	15.7	2,219	14.0	2,147	13.8
San Benito	138	11.3	140	11.6	130	10.9
San Bernardino	2,664	17.0	2,616	17.1	2,452	16.3
San Diego	4,175	16.9	3,890	16.1	3,545	15.0
San Francisco	8,219	12.0	7,283	10.8	7,125	10.7
San Joaquin	1,854	16.6	1,647	14.9	1,580	14.5
San Luis Obispo	483	14.8	465	14.5	436	13.8
San Mateo	653	7.0	563	6.2	557	6.3
Santa Barbara	1,128	15.2	1,117	15.3	1,109	15.5
Santa Clara	2,385	14.7	2,114	13.3	2,029	12.9
Santa Cruz	579	13.9	546	13.3	524	13.0
Shasta	281	19.9	282	20.0	254	18.0
Sierra	17	6.4	26	9.9	35	13.5
Siskiyou	385	13.7	370	13.4	341	12.5
Solano	469	11.4	440	10.7	413	10.1
Sonoma	746	11.3	744	11.4	683	10.5
Stanislaus	1,275	20.1	1,120	18.4	1,056	17.6
Sutter	291	17.8	273	17.0	277	17.5
Tehama	267	18.8	213	15.0	224	15.9
Trinity	21	7.2	40	13.9	46	16.0
Tulare	1,869	22.1	1,662	19.9	1,564	19.0
Tuolumne	142	14.4	113	11.6	106	10.9
Ventura	1,171	18.0	1,126	17.8	1,061	17.1
Yolo	342	13.1	311	12.1	308	12.1
Yuba	246	21.0	210	18.0	178	15.4

Births by races for the years 1935, 1936, and 1937 are as follows:

	1937		1936		1935	
	Number	Per cent	Number	Per cent	Number	Per cent
Totals	94,286	100.0	84,460	100.0	80,222	100.0
White	77,576	82.3	68,249	80.8	64,508	80.4
Negro	1,534	1.6	1,305	1.6	1,247	1.5
Indian	436	0.5	429	0.5	401	0.5
Chinese	542	0.6	537	0.6	517	0.6
Japanese	1,436	1.5	1,448	1.7	1,502	1.9
Mexican	12,173	12.9	12,156	14.4	11,752	14.7
Filipino	377	0.4	188	0.2	295	0.4
Others	212	0.2	148	0.2		

HOW ORGANIZED NURSING LOOKS UPON NURSING HOURS*

Facts, Not Rumors Wanted.—Last year the Nursing Information Bureau of the American Nurses' Association adopted the policy of publishing a bulletin only when something urgent and important needed to be broadcast to registered nurses all over the country. Such a time seems to be here now!

Rumors and rumblings about the eight-hour day, not enough nurses to care for the sick, not enough students for nursing schools, inadequate preparation for nursing jobs, and unskilled services of various kinds, permeate the atmosphere of the nursing world and are seeping into that of the general world as well. But are they based on facts? Actual data can be found in current literature. Here are some of them.

* This bill was passed and is now a New York law.

* From *The Bulletin*, published for the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing. (Vol. 9, No. 1, December, 1937.)

The Eight-Hour Day Is Here to Stay.—Hospitals, one by one the country over, are discovering that eight-hour service means better nursing service for patients and a more contented nursing personnel. Evidence is the fact that calls for eight-hour service are going up in number, and calls for nurses for twelve-hour service are on the wane. By December, 1937, 899 hospitals throughout the United States reported to the American Nurses' Association that they had adopted the eight-hour schedule for special nurses. This represents a steady increase in number since 1934, when only 278 had adopted it.

Why this comparison with conditions in 1934? Because at the biennial convention of that year, the American Nurses' Association proclaimed that, "In the interest of good nursing, we believe that nurses in caring for *acutely ill persons* should not be expected to work more than eight hours out of twenty-four." Since then, through intensive field work rendered by the American Nurses' Association headquarters staff, through the wide distribution of printed material, through illustrated talks and radio speeches, and through individual and group conferences, the American Nurses' Association has carried on an active educational program in behalf of the eight-hour day. State nurses' associations and their unit members have coöperated with the American Nurses' Association in this program and are pushing it forward so effectively that the combined efforts of national, state, and local groups are slowly but surely convincing all of the rightness of the eight-hour schedule.

Factors Affecting Employment of Nurses: Increased Demand for Nursing Service.—Between 1930 and 1935, the capacity of hospitals throughout the country increased by 119,270 beds.[1] And, for the last twenty-seven years, the capacity of hospitals has been increased by an average of 25,024 beds a year.[2]

Since 1932 the number of hospitals with schools which employ graduate nurses for bedside care has increased by 55 per cent.[3]

In 1934, according to registrars' reports to American Nurses' Association headquarters, 12 per cent of the nurses on call were unemployed all month; in 1936, only 2 per cent were unemployed all month.[4]

Also, in 1934, 25 per cent of the nurses on call reported twenty or more days'employment a month; in 1936, 34 per cent were employed twenty days or more a month.[4]

Economic Conditions.—Calls for private duty nurses for eight-hour service have increased from a monthly average of 41.91 per cent in 1934, to 59.84 per cent in 1936; while calls for twelve-hour service have decreased from a monthly average of 47.70 per cent in 1934, to 32.27 per cent in 1936.[5]

According to reports of registrars, "Registrants are unwilling to accept prevailing conditions of employment for general staff nursing."[6]

Nearly half of the directors of nursing schools employing general staff nurses who answered the National Information Bureau's fall questionnaire, believe that "low salaries" are largely responsible for their difficulty in securing general staff nurses. Other factors given are: long or broken hours of work; unsatisfactory living conditions; too heavy a load of work to permit good nursing.[7]

According to Joint Vocational Service, "low salaries" are largely responsible, also, for difficulty in securing well-qualified nurses for supervisory, teaching, and executive positions in public health nursing.

Staff Education Programs.—"In only 50 per cent of the hospitals (reporting) are the general staff nurses given the opportunity to attend regular staff conferences and to participate in discussions about the conduct and procedures of the nursing service."[7]

Basic Preparation of Nurses.—One of the requirements which nurses must meet in order to qualify for public health nursing positions, especially those created as a result of the Social Security Act, is: "Graduation from an accredited school of nursing connected with a hospital having a daily average of one hundred patients, or a minimum of fifty patients with one or more affiliations affording supplementary preparation." According to the League's 1935 list of schools meeting the minimum requirements set by law in the states, 363 schools were connected with hospitals having a daily average of less than fifty patients and 833 with hospitals having a daily average of less than one hundred patients.

A requirement for registration imposed by law in some of the states is that applicants must have completed a course of instruction in nursing covering not less than thirty-six months. In most states where this three-year law obtains, nurses who have not had a full three-year course cannot make up the deficiency in time through post-graduate work.

Do these factors which affect the employment of nurses hold true for your hospital, community, or state?

Are There Enough Qualified Nurses?—According to reliable sources, not enough qualified nurses are available for existing nursing positions. Directors of hospital nursing services report difficulty in securing a sufficient number of qualified nurses for general staff nursing positions.[8]

Registrars reported a one per cent increase in the number of unfilled calls in 1936 over 1935.[9]

The recent census of public health nurses shows that at present the ratio of public health nurses to population is 1:7000, while a desirable ratio is 1:2000.[10]

Joint Vocational Service reports a dearth of public health nurses well qualified for supervisory and teaching positions.

These statements apply to the country as a whole. What is the situation in your community?

Fall 1937 Enrollments.—The Nursing Information Bureau voices a large *Thank you* to all the directors of nursing schools who filled out and returned the questionnaires on fall enrollments in October. The findings from the questionnaire appeared in the December issue of the *American Journal of Nursing* under the title, "Student and Graduate Nurses—Are There Enough?" In a nutshell, the findings are:

1. More students enrolled in nursing schools in the fall of 1937 than in the fall of 1936.

2. However, the increase in admissions, 1937 versus 1936, was only one per cent, compared with a five per cent increase, 1936 versus 1935.

3. Nevertheless, 64 per cent of the schools were satisfied with the number of students enrolled; 36 per cent were not.

4. Fifteen per cent of the students enrolled in 1937 have had one or more years of college work, compared with 14 per cent in 1936.

5. And approximately two-thirds of the students who have completed high school only stand in the upper third of their classes.

6. Graduate staff nurses for general duty service are employed in 88 per cent of the hospitals connected with nursing schools which replied to the questionnaire. Their number totals approximately 20,500. In 1932, nearly two-thirds of the schools did not employ even one graduate nurse for bedside nursing.

7. In 55 per cent of these hospitals, directors of nursing services have experienced difficulty in securing qualified graduate staff nurses. In 45 per cent they have not.

8. Subsidiary workers, in the form of ward attendants, helpers or aides, are employed in 71 per cent of the hospitals replying to the questionnaire. The actual number so employed in these institutions is 13,562.

The Accrediting Committee Acts.—The Committee on Accrediting of the National League of Nursing Education

1 J. A. M. A., p. 185B, June 5, 1937.
2 J. A. M. A., p. 1036, March 27, 1937.
3 A. J. N., p. 1364, December, 1937.
4 A. J. N., p. 731, July, 1937.
5 A. J. N., p. 471, May, 1937.
6 A. J. N., p. 736, July, 1937.
7 A. J. N., p. 1365, December, 1937.
8 A. J. N., p. 1365, December, 1937.
9 A. J. N., p. 736, July, 1937.
10 P. H. N., p. 651, November, 1937.

has swung into action. At a meeting of its Executive Committee on October 30, it was decided that the coming year is to be spent developing accrediting criteria, testing their application in a limited number of representative schools, and making studies of the costs of surveys which are a necessary part of the committee's work. The expense of this first year's work will be borne by the Accrediting Committee.[11]

The central aim of the committee, of course, is "to stimulate, through accrediting practices, the general improvement of nursing education and nursing practice in the United States." Other aims include "helping those responsible for the administration of schools of nursing to improve their schools, publishing a list of accredited schools, and promoting interstate relationships in the professional registration of nurses."[11]

Excerpts from the Curriculum Guide.—The Curriculum Guide for Schools of Nursing is proving itself a professional best seller. It was completed in July, and 4,000 copies of it have already been sold. This book may be purchased from the National League of Nursing Education, 50 West Fiftieth Street, New York City, for $3.50.

What are its purposes and recommendations? Here are some of them: "The League's primary objective in preparing and publishing its Curriculum has been to encourage schools to study their own educational problems and to provide guidance to those interested in revising or building curricula for their nursing schools."[12]

Should nurses be trained or educated? The answer is for you to give. The Curriculum Guide states, however: "Training is a matter of fixing habits and skills by a process of repetition so that when a given situation presents itself a certain definite response will automatically result. . . . Where training methods predominate, the tendency is to emphasize obedience to the orders of others and to demand conformity to certain prescribed patterns of thought and behavior, to stress the practical utilitarian types of habits and skills, and to pay little attention to intellectual and social skills or to the development of personality. Education, as contrasted with training, is concerned with the growth of the whole individual. While it includes training and discipline, it emphasizes the control of habit by intelligence and the variation of responses to meet the demands of each situation."[13]

"If the main aim of nursing is to help the patient regain and maintain health . . . and if in certain cases activities such as cleaning the room, bathing the patient, taking temperatures, and serving diets, can be carried on by a non-professional person in such a way as to achieve these results satisfactorily, such duties should be assigned to those who can do them at the lowest cost commensurate with good results."[14]

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

Human Cases of Rabies*—Years 1936, 1937, 1938

TABLE 1.—*Incidence of Rabies by Counties in California*

County	1936	1937	1938†
Imperial	1		
Kings			1
Los Angeles		3	2
Totals	1	3	3

TABLE 2.—*Distribution of Human Cases of Rabies by Counties*

From date of first case in year 1899.

Year	Number	Location
1899	1	Pasadena
1909	1	Holtville, Imperial County
1910	3	Los Angeles 2
		Rivera, Los Angeles County 1
1911	3	Los Angeles 2
		Tulare County 1
1912	9	Santa Maria 1
		San Francisco 6
		Los Angeles 1
		Sacramento 1
1913	8	San Francisco 3
		Lincoln 1
		Newcastle 1
		San Bernardino 1
		Santa Rosa 1
		Oxnard 1
1914	3	Oakland 1
		Hanford 1
		Anaheim 1
1915	5	Santa Cruz 1
		Watsonville 1
		Oakland 1
		Emeryville 1
		Los Angeles 1
1916	1	Bieber, Lassen County
1920	4	Fresno 1
		Stockton 1
		French Camp 1
		San Joaquin County (rural) 1
1921	5	Sacramento 2
		Tulare 1
		Antioch 1
		Los Angeles 1
1922	4	Los Angeles 3
		Venice 1
1923	11	Los Angeles 7
		Tustin, Orange County 1
		Duarte, Los Angeles County 1
		San Bernardino 1
		Fresno County (rural) 1
1924	5	El Centro 1
		Downey, Los Angeles County 1
		Los Angeles 3
1925	1	Glendale 1
1926	5	South Gate, Los Angeles County 1
		Huntington Park 1
		Los Angeles County (rural) 3
1927	1	Santa Maria 1
1928	3	Pasadena 1
		Los Angeles 1
		La Crescenta, Los Angeles County 1
1929	2	Watts, Los Angeles County 1
		Lomita, Los Angeles County 1
1930	1	Corona, Riverside County 1
1931	2	Fowler, Fresno County 1
		Los Angeles 1
1932	2	Glendale 1
		Le Grand, Merced County 1
1933	0	
1934	1	San Diego 1
1935	1	Los Angeles 1
1936	1	Calexico 1
1937	3	Los Angeles 1
		Altadena 1
		San Gabriel 1
1938 (to Apr. 16)	3	Los Angeles 2
		Hanford 1
	89	

TABLE 3.—*Incidence of Rabies in City of Los Angeles*

	1935	1936	1937	To Apr. 1 1938
Human cases (fiscal year)	0	1	1	
Human cases (calendar year)	1	0	1	2
Animals				
Dogs (fiscal year)	229	360	564	
Dogs (calendar year)	254	350	832	102
Cats	3	6	9	
Cows	2	0	4	
Horses	0	1	0	
Racoons	0	1	0	
Mules	0	0	1	
Rabbits	0	0	1	
Total cases in animals (includes all above animals):				
For fiscal year	234	368	579	
For calendar year	259	358	847	117

11 A. J. N., p. 1380, December, 1937.

12 A Curriculum Guide for Schools of Nursing, p. 5 (Foreword).

13 *Ibid.*, pp. 30-31.

14 *Ibid.*, p. 26.

* From the California State Department of Public Health.

See also editorial comment in this issue, on page 308.

† For the year 1938, figures are inclusive for the period January 1 to April 16, 1938.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 5, May, 1913

From Some Editorial Notes:

Who Are Your Friends?—There are a number of people who have been pretty good friends of yours; it is beside the question that they are working for their own reasonable profit. They have helped you to build up your JOURNAL and they make it possible for you to have a journal of the size and make-up of the STATE JOURNAL. Do you trade with your friends, other things being equal, or do you not? Did you ever stop to think that there is scarcely a thing that you need to buy, from green soap to groceries, from surgical instruments to sermons in print, and that there is not an institution to which you may wish to send a patient, that is not advertised in your JOURNAL? If you do not believe this—and there are always some who will not believe without evidence—just look carefully through the advertising pages and you will be convinced. In these pages your friends, your advertisers, present for your notice and attention a great variety of wares; all are good and reliable, or they would not be there. Recognize your friends when you see them and deal with them as they deal with you.

* * *

The Annual Meeting at Oakland.—The forty-third annual meeting of the State Society, held at Oakland April 15, 16 and 17, was a great success. It is not possible to print all the reports, minutes, etc., in this issue of the JOURNAL, and so they will all be held back and the whole story will be printed in the June number. The registration was the largest in the history of the Society—618.

The officers elected for the year are as follows: President, F. C. E. Mattison, Pasadena; first vice-president, Barton J. Powell, Stockton; second vice-president, George Tucker, Riverside; secretary, Philip Mills Jones, San Francisco; councilors, George H. Kress, C. G. Kenyon, J. H. Parkinson, O. D. Hamlin.

* * *

A Most Valuable Book.—Beginning, some seven years ago, as a very small pamphlet, the annual edition of "New and Nonofficial Remedies" has grown till the edition for 1913 has indeed reached a most respectable size. It is a book that should be on the desk of every physician who ever writes a prescription. It is difficult enough, even with all the tremendously valuable work that the Council on Pharmacy and Chemistry of the American Medical Association has done for us, to tell those remedies which are decently and honestly made and marketed from those that are not; it is impossible to do so without frequently consulting this book.

* * *

On a New Kind of Surgical Literature.—It is time that the eye of reprobation be more specifically directed toward a new and regrettable departure in surgical literature. Certain publications have appeared in the near past whose purpose appears to be the exploiting of the surgical, and especially the operative skill of their authors, without permitting us to judge with any degree of certainty for ourselves of the quality of those virtues. Proclaiming themselves greatly sired, these books are in nowise great.

* * *

The American Royal College of Surgeons—J. B. M.—In this fair month of May, in the good city of Washington, is to be held a most remarkable meeting for the purpose of conferring upon American surgeons (query: who—or what—is a surgeon?) a collection of letters indicative of some title, both title and string of letters being subjects for discussion. Martin (of *Surgery, Gynecology and Ob-*

(Continued in Front Advertising Section, Page 19)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Attorney-General U. S. Webb, in an opinion to State Insurance Commissioner Samuel Carpenter, today said that the National Protective Association of Los Angeles is taking in members on a contract which violates a previous ruling that corporations cannot engage in the practice of medicine. . . ." (Sacramento *Bee,* March 24, 1938.)

"The Association of Western Hospitals and the Western Conference of the Catholic Hospital Association were on record today in opposition to anticipated legislation which would force public hospitals supported by taxation to throw open their doors to any patient, regardless of his ability to pay for private hospitalization. . . ." (Oakland *Tribune,* March 4, 1938.)

"A. I. Stewart of Pasadena is the new State Director of Professional and Vocational Standards. His appointment to the $6,000 a year cabinet post was announced last night by Governor Frank F. Merriam, the statement describing the new state officer as a past president of the California League of Municipalities. Stewart will enter the Governor's cabinet as the successor of William G. Bonelli of Los Angeles, resigned to accept a Merriam appointment to the State Board of Equalization." (Sacramento *Bee,* April 7, 1938.)

Report of the Investigation Department relates that Ernest George Wollenweber, M. D., said to have been a former practitioner of Iowa, recently pleaded guilty to one of four counts of violation of the Business and Professions Code and was sentenced to serve ninety days in the county jail and to pay a fine of $100, jail commitment being suspended, as well as $50 of the fine, on condition that he in future abstain from violating any of the laws of the State of California. He is reported to have come to this state and associated himself with a licensed California physician, without even the formality of applying for a license to practice in this state.

Recent reports from Topeka, Kansas, related that an impostor, known as J. Therman Steele (and with a host of aliases), had recently been imposing upon the medical practitioners of that state, issuing fraudulent checks. He was apprehended in Los Angeles, where the police found he had quite a criminal record, and has been returned to Topeka, Kansas, for trial. He is just another of the host of impostors who prey upon the medical profession by false claims of medical education and licensure.

Olea Moreno, alias Cleopas O. Marino, recently charged in Imperial County with alleged violation of the Business and Professions Code, was said to have been imposing upon the inhabitants of Imperial County. Among his asserted credentials was a framed certificate bearing the caption "International Spiritualist Union, Omaha, Nebraska." This certificate was said to empower him to perform the marriage ceremony, conduct burial service, make reasonable charge therefor, and "to exercise all other functions usually granted in the rite of ordination." Our investigator reported "one case in which there is not ample evidence to support it, is that of a Mexican woman, who suffered from appendicitis. He ordered four people to hold this woman over a flame, the flame touching her abdomen. This was said to have been done in his so-called temple. He said he would burn out the evil spirits."

(Continued in Front Advertising Section, Page 24)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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M. Burneice Larson, Director

PHYSICIANS•HOSPITAL ADMINISTRATORS•GRADUATE NURSES•DIETITIANS•TECHNICIANS

How do you do it all?

Tonight, Doctor, after the last patient has gone, when the day's trying cases have been reviewed and recorded, when all that life has piled on tired and willing shoulders has had its will of you . . .

. . . we ask that you sink into an easy chair and let the old fighting chin rest on your necktie and *think* the whole long evening through on these questions:

How *do* you do it all?

Is all you do *worth* the doing?

Do you ever rest? travel? play golf? Do you ever *work* in your study on pet theories? Do you ever find time to *write* the priceless things you know?

Shouldn't you do *all* of these? Would you? if you could? Isn't it truth that little, *inconsequential* things are barriers to the finer things you would love to do?

In our files, in our memories, we will find for you *some day* (the day you ask us to), a man, a physician, a man who'd be release for you to *hours* and *days* and *weeks* and *years* . . . to do with as you will.

We would find a man to come to you to do gladly the things you call *beginners'* tasks; tasks that take your years and make them *less* than you would make them; tasks that give *him* skills and poise and judgment that come only from doing.

The plan would give you TIME . . . *years* . . . to do with as you will . . . to lengthen life, to make it sweeter, to make it give the *greater* things. . . .

Will you write us . . . soon. . . .

Our BOOTH at the meeting of the

California State Medical Meeting, May 9–12, is number fourteen
American Psychiatric Association, June 6–10, is number eleven
American Medical Association, June 13–17, is number eighty-eight

The MEDICAL BUREAU

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Rabies in Wild Animals in California.*—There is no direct evidence as to when rabies first appeared within California, but Dr. George Lyman in his book, "John Marsh, Pioneer," refers to the presence of rabies in dogs and to cases of hydrophobia" cared for by Doctor Marsh in the early forties. This pioneer physician lived in the vicinity of the present community of Brentwood, in Contra Costa County, and he was the only practitioner of medicine in this extremely sparsely populated district. He is known to have traveled at least seventy-five miles in order to care for patients in his extensive practice.

In 1909, a school teacher of Morgan Hill, in Santa Clara County, went on an outing with three young boys to Coyote Creek, several miles east of Morgan Hill. The three boys were bathing in the stream when a lioness appeared suddenly, attacking one of the boys, striking him with her claws and leaving wounds in his scalp and ear. The teacher ran to his assistance and the animal jumped upon her, knocking her down. In an effort to prevent attacks on her head and face, she raised her left arm and attempted to jab the lioness with a hatpin. The teacher was badly wounded, her left arm being mangled from bites and scratches, with gashes on the right arm, leg, and back. There were also scratches and abrasions on her head and face. Seven weeks later, after an apparently uneventful recovery, the woman was taken violently ill with spectacular symptoms and died within one week. The boy, who was first attacked by the lioness, returned to his home in Santa Cruz, where he died, with the cause of death pronounced as tetanus.

These cases were brought to public attention in 1923 by Dr. Tracy I. Storer, now professor of Zoölogy in the University of California College of Agriculture at Davis. Fourteen years after the occurrence, he painstakingly resurrected all the presumptive data, including reports of physicians who had attended one of the cases. It was agreed that the cause of death was rabies, and not tetanus. The incubation periods and other factors virtually proved the diagnosis. At that time, laboratory service for the diagnosis of rabies was not readily available; and, while the evidence is purely circumstantial, there is every indication that the mountain lion that attacked these individuals was suffering from rabies.

The first recorded appearance of rabies in California dogs was in Pasadena in 1899. At various times suspected cases in wild animals were reported after 1899; but it was not until 1915, when an extensive outbreak of the disease occurred in Modoc and Lassen counties, that the prevalence of rabies in the wild animals of California was proved. The reports of rabies in northeastern California in 1915 included the following comments relative to rabies in coyotes:

"One coyote came into a rancher's yard, passed through a flock of turkeys, apparently without noticing them, and was killed by the rancher at his very doorstep.

"Another one came into the yard, biting and attacking several chickens, snapping at everything he saw, and after being killed it was found that his stomach contained nothing but bits of wood.

(Continued on Next Page)

* See also editorial comment in this issue.

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(Continued from Preceding Page)

"Mr. Sans, of the United States Biological Survey, reports that several trains in Nevada have recently run over six coyotes that, at different times, had gotten on the tracks while biting and snapping at the locomotive.

"While in an automobile in the Surprise Valley, Mr. Sans states that he passed a herd of cattle and saw a coyote in the midst of the herd, biting and snapping at the cattle. When he stopped the machine, the coyote ran at it and was shot while within ten feet of the machine. This head, upon examination, proved positive for rabies. Five animals in the herd died of the disease.

"In another instance, a coyote chased a boy into the yard. He slammed the gate just in time to save himself, and the coyote began to gnaw and bite at the pickets. It was shot, and upon bacterial examination the case proved positive for rabies.

"In another place, a coyote ran into a railroad roundhouse and attacked an employee. It was killed before biting the man. This case was proved bacteriologically also.

"A government surveyor in Nevada was bitten at night by a coyote that ran into his tent. An examination of this animal's head also proved that it was a positive case of rabies.

"In a small town in Nevada, a coyote ran into a bunkhouse, jumped on a man's bed, tearing and biting at the covers. The man saved himself by pulling the covers over his head and calling for help. Before the coyote was killed, four dogs, three hogs, and one horse were bitten, and later died of rabies."

During the past fifteen years, 1922 to 1937, cases of rabies in the following numbers of wild animals have been reported to the California State Department of Public Health:

Coyotes	25
Skunks	5
Foxes	2
Raccoons	2

It is reasonable to assume that many cases of rabies have occurred in wild animals, and that these figures represent only a few of the cases that have actually occurred. It would seem, in fact, that rabies is primarily a disease of wild animals and that the dog population has contracted the disease through contact with carnivorous animals living in the wild.

The recent occurrence of rabies in a "bobcat" in Colusa County indicates the importance of observing possible cases of rabies in wild animals at the present time. In this instance, a wildcat is said to have suddenly appeared from a roadside and leaped upon the hood of a school bus carrying seven children. The animal scratched and tore at the windshield before falling from the machine. It is said to have sunk its teeth into one of the front tires and was rendered unconscious by the force of its contact with the front wheel of the bus. One of the older students cut the throat of the animal with his pocket knife. The head was sent to the State Laboratory for examination, where positive results were obtained. Because of the fact that the boy's hands bore abrasions, he is being given the Pasteur treatment for the prevention of rabies.

Reports of suspected cases in mountain lions in several districts of the state have been received recently, and there would seem to be justification at the present time for taking proper safeguards against attacks by rabid animals in the outlying districts of the state. Ordinarily, wild animals shun man and his habitations; but when rabies is epidemic it is safer to exercise ordinary precautions against attacks.

Cancer Exhibit of the New York World's Fair, 1939. Hope for the thousands throughout the world afflicted by cancer, with dramatic demonstrations by dioramas of what science is accomplishing in fighting the scourge, is the theme of an exhibit to be made at the New York World's Fair in 1939 by the New York City Cancer Committee of the American Society for the Control of Cancer.

Contract for 500 square feet of display space in the exposition's $400,000 Medicine and Public Health Building was signed on March 18 by Dr. Francis Carter Wood, Di-

(Continued on Page 38)

●

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

III. EXHAUSTING OR PREHEATING

● Modern canning procedures provide for the exclusion from the sealed container of air, and other gases present in raw food material, to the greatest possible degree.

In the sealed can, oxygen, in particular, is undesirable, whether it be released from food cells or be present in the form of entrapped air. If present in the sealed tin container, oxygen can react with the food and the interior of the can and directly affect the quality, nutritive value and merchantable life of the canned food. Other gases—for example, carbon dioxide produced by cellular respiration—should also be excluded as far as is practical. If present in large amounts, these gases may place undue strain on the container during the heat process to which canned foods are subjected.

In commercial canning practice, certain operations—specifically the blanch—may aid in elimination of gases from raw food tissues. However, main dependence is placed upon what are known as "exhausting" or "preheating" operations, not only to expel gases from raw foods, but also to exclude air from the can.

Briefly, the exhausting operation is accomplished by mechanically passing the open can containing the raw food through a so-called "exhaust box" in which hot water or steam is used to expand the food by heat and drive out air and other gases contained in the food and in the can. The times and temperatures used in commercial exhausting operations will naturally vary with the nature of the product (1).

After exhausting, the can is immediately permanently sealed, heat processed and cooled. During cooling, the contraction of the heated contents of the can creates the vacuum normally present in commercially canned foods.

With certain products, instead of exhausting as described above, the same effect is produced by preheating the food in kettles or similar devices; filling into the cans while still hot; and immediately sealing the containers. With still other products, an exhausting effect is produced by adding boiling water, syrup or brines to the food in the can. In some instances, exhausting is accomplished by mechanical rather than by thermal means. Specially designed sealing or "closing" machines are used to withdraw air and other gases by applying high vacuum to the can and immediately sealing on the cover.

Such in brief are the purposes of commercial exhausting operations and the means by which they are usually accomplished. Modern canners recognize that these operations are most important to the success of their canning procedures. They appreciate that only by strict supervision and control of exhausting operations can the quality and nutritive values of their products be maintained at a consistently high level.

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(1) Appertizing or The Art of Canning", A. W. Bitting, The Trade Pressroom, San Francisco, 1937.

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(Continued from Page 36)

rector of the Institute for Cancer Research, Columbia University, and Grover A. Whalen, President of the Fair Corporation, in the latter's office in the Empire State Building.

The contract is the first to be signed for exhibit space in the Medicine and Public Health Building, which is now built and will be ready for inspection by visitors on the occasion of the Fair's great Motorcade and Preview on April 30 next, just a year to the day before the exposition gates are to be opened.

In explanation of the intent of the exhibit, Dr. John C. A. Gerster, Chairman of the New York City Cancer Committee, said:

"The exhibit will include a presentation of the powerful weapons which can be used in the war to conquer the disease, which takes an annual toll of more than 140,000 lives in this country.

"The plan is to give the public an opportunity to study a cancer exhibit primarily designed to make people conscious of the fact that cancer, if adequately treated in time, is curable in a large percentage of cases.

"It will be pointed out that the three recognized forms of treatment are: surgery, x-ray and radium, and that the public must do its share in acquiring knowledge necessary to fight the disease. The keynote of the exhibit is to be Hope—which, after all, is the basis of the entire program in cancer education."

Among the dioramic presentations to be made in the treatment category will be an exact reproduction in miniature of the Paris laboratory of Marie and Pierre Curie where, in 1898, they discovered radium. The model, with lifelike figures of M. Curie and his wife, will show them at their work bench, intently watching a substance which glows, in symbolism of their tremendous discovery. Beside the diorama is to be shown the identical watch belonging to Mme. Curie by which the time of radium dosage was originally determined. Supplemental models will show how radium is mined and refined in Canada and the Belgian Congo.

Another diorama is to be a similar reproduction of the laboratory of Wilhelm Konrad Roentgen in Wurzburg, Bavaria, in which, in 1895, the great physicist, made his startling discovery of the x-ray. A spark in a diminutive tube is to indicate the discovery.

In the case of each of these dioramas, the equipment is to be identical with that used by the scientists, these having been contrived from measurements, diagrams, and photographs of the originals. There will be, in addition, a full-size reproduction of the x-ray tube used by Roentgen.

As deep x-ray therapy has become one of the agencies in treating cancer, the exhibit is to include a model of the 1,000,000-volt x-ray machine designed by Doctor Wood and used by him in giving treatments at Presbyterian Hospital, and also one of the 400,000-volt machines used generally in hospital practice.

In the field of surgery in treatment of cancer, the dioramas are to be equally dramatic. One will present a scene in ancient Babylonia, with sick persons on stretchers and the general public gathered about eager to give advice; another will show a medieval hospital, where only the most simple needs could be met. Nearby, a barber-surgeon of the sixteenth century, with his "magic wand" for diagnosis, and propensity for cupping and leeching and little other knowledge, is to be shown.

Coming down the years, dioramas are to portray the plague doctor and the crude surgical practices of the seventeenth century, and, in sharp contrast, the well-equipped operating room of today, with its advantages of anesthetics and of antiseptics resulting from the studies of Pasteur and Lister.

The life-size figure of a woman etched on glass and lighted from the back will be shown to reveal the manner in which cancer may spread through the body if not properly diagnosed and treated in time. A motion picture, prepared under direction of Doctor Wood, is to tell the story of experimental work in cancer, illustrating the method of inoculating mice and rats with the disease and how the

(Continued on Page 40)



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(Continued from Page 38)

progress of the infection is watched and studied. Also, cancer statistics from one hundred countries are to be displayed to show that the disease is a world problem.

The Treatment of Syphilis Versus Treatment of Wassermann Reactions.—Dr. Matthias Nicoll, Jr., Commissioner of Health, Westchester County, New York State, discussed recently, in the bulletin issued by his department, the significance of the Wassermann reaction as an index to the presence of syphilis. He said:

It is generally accepted that a Wassermann reaction denotes active syphilitic infection except in the presence of malaria, leprosy, yaws (which may or may not be a form of syphilis) and certain acute febrile states. However, this is an assumption and not a proven fact. There are those who believe the Wassermann reaction in late syphilis is of no more significance than a tuberculin reaction in tuberculosis, that it has little, if any, bearing on the present activity of the underlying disease, although its presence unquestionably demands a thorough physical overhauling of the patient, with special attention to the central nervous system (including the eye grounds) and the cardio-vascular system.

In the management of cases of syphilis, he said:

Treatment of the early case of syphilis is relatively easy. As a rule, such patients respond quickly to treatment and serological as well as clinical cure usually results within two years. But the old case of syphilis who may have been infected five or more years previously is a decidedly different problem. If spinal fluid findings are negative, the eye grounds are normal, the cardio-vascular system is negative and there are no manifestations of syphilis other than a Wassermann reaction, a similar course of two years' continuous treatment using both arsenicals and heavy metal should suffice. If the Wassermann test remains positive (as it probably will), well and good. Let the physician and the patient forget it. It is extremely doubtful that the latter will develop subsequently any late manifestation of the disease and his life expectancy will probably not be increased by treatment.

Motor Vehicles Checked for Poisonous Gases.—Honk! honk! A giant truck with red cab, red trailer, and house-high superstructure roars around the bend on the ribbon-like highway and starts to climb the grade over California's famed Tehachapi Pass. This is only one of thousands of such vehicles that carry the state's agricultural crops and merchandise of all sorts from north to south and south to north. Like slow-crawling dragons they creep over the mountain passes, smoke emitting from their Diesel motors, and pale exhaust gases from those equipped with standard motors.

At a small depression in the mountains where there is a short stretch of nearly level highway, stand a highway patrolman and a young doctor with strange-looking boxes that contain scientific equipment. The patrolman signals the truck driver, and the Leviathan comes to a slow stop. The head of the driver leans out of the half-open cab window.

"What's wrong, Buddy? I'm not overweight."

"Nothing wrong, yet," responds the patrolman. This doctor is from the State Department of Public Health and he wants to test your bus for poisonous gases in the exhaust, to find out if you're in danger of passing out."

"O. K.! Glad to find out about that. Sometimes I get sleepy going over the hump. The steady roar of the old motor sort of puts you to sleep, but sometimes I think that the sleepiness when I'm on the grade has a headache along with it and I don't feel so good."

"We'll find out about that," says the young doctor. "I'll put my instruments on your floor board, get in the cab with you, and make the test while you are running. It wouldn't be a fair test if we were at a standstill with your motor running. We might get unreliable readings because of leakage of gases through cracks between the floor boards."

"What gas is it that is so poisonous?" asks the driver.

"Carbon monoxid," replied the doctor. "The same old CO that used to cause so many deaths in the days of artificially manufactured domestic and illuminating gas. It is released in the combustion of gasoline and, while it is very

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dangerous, it is impossible to recognize its presence except through a scientific test such as this. The gas is colorless, odorless, and in sufficient quantity might produce death without the victim ever knowing what happened to him. In small quantities it may produce drowsiness, headache, nausea, dizziness, weakness, or difficult breathing."

The doctor rode in the cab with the driver for several miles—a five-minute run—at the end of which time he took readings from his instruments to measure the carbon monoxid in the atmosphere.

"Well, Doc, what's the answer?" asked the driver.

"You are exposed to a dangerous concentration of carbon monoxid—150 parts per million. The presence of more than 100 parts per million constitutes a serious health hazard. No doubt your drowsiness and headaches were due to this exposure. Many accidents supposed to be due to a sleepy driver are actually due to carbon monoxid poisoning. You'd better find the mechanical defect that causes this concentration of gas."

"I know right now," replied the driver. "The exhaust pipe gasket blew out a month ago and I didn't have any repairs made because I didn't regard it as necessary. I'm going to get a new gasket installed at the next stop. Thanks for the test, Doctor. No more headaches for me!"

During the past month the California State Department of Public Health Industrial Hygiene Service has, in cooperation with the State Highway Patrol, tested 688 motor vehicles for the determination of carbon monoxid. They were distributed as follows:

Truckee and Donner Grade	70
Dunsmuir	134
Altamont Pass	191
El Tejon Grade (Ridge Route)	154
San Gorgonio Grade (Banning)	139
Total	688

Of these, the drivers of twenty-four vehicles (or 3.47 per cent of the total) were found to have been exposed to

(Continued on Next Page)

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Rates, Information and Booklet on Request

(Continued from Preceding Page)

dangerous concentrations of carbon monoxid while operating vehicles on the highway.

These investigations, undertaken by Dr. J. P. Russell of the Industrial Hygiene Service of the California State Department of Public Health, will be continued during the coming weeks. Drivers of motor vehicles, in order to play safe, should always keep car windows open while driving. If drowsiness and headache occur, it is safer to have the mechanical equipment checked and corrected, if found faulty, than to take a chance of incurring an accident or serious illness by carbon monoxid poisoning.

Eye Hazards in Industry.—The eye hazards in industry constitute one of the principal causes of blindness in America. Every year hundreds of men and women lose their sight, and thousands of others suffer serious eye injuries, through occupational accidents.

It is estimated that the industries of America would save $50,000,000 a year if known methods of eliminating eye accident hazards were conscientiously observed by employers and employees. Aside from the humanitarian aspect, it is cheaper to prevent accidents than to pay for them.

When an individual worker—man or woman—suffers a serious eye injury, a long chain of costly interruption of work ensues.

One cannot estimate in terms of dollars, of course, the tragedy that enters every home in which a person has been blinded or has lost part of his sight permanently.

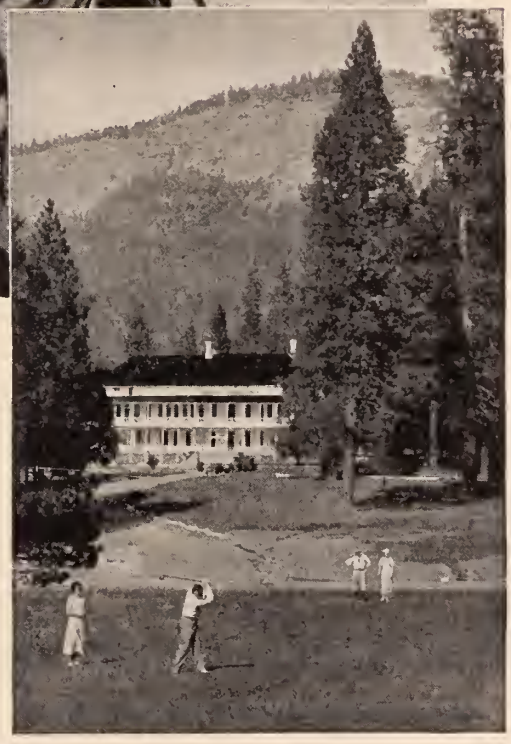
What are the eye hazards in industry? Briefly, they are the accident hazards, the disease hazards, and the hazards of excessive eye fatigue. The accident hazards are produced chiefly by flying chips of metal, wood, rock, or other hard substances; by falling or thrown tools, raw materials, and other large objects; by the splashing of molten metal or injurious chemicals. Disease hazards affecting the eyes with which industry is or should be concerned are the venereal diseases, trachoma, cataract, nystagmus, and the general toxic effects of those poisonous chemicals commonly

(Continued on Page 45)

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(Continued from Page 42)

used in many industries which may affect the eyes as well as other organs. The hazards of excessive eye fatigue are those due to insufficient light, too much light (glare), flickering light, or too long neglect of eye conditions requiring refraction or other corrective measures.

The accident hazards are, of course, the most serious of all these. How can these hazards be eliminated or their effects counteracted? Briefly, they can be prevented in three ways: (1) by the provision of protective equipment, such as goggles and head masks for individual workmen, screens of metal, wood or canvas between workmen and glass shields or other approved protective devices at the point of operation of emery wheels and other machines, operation of which is attended by flying particles, or splashing of molten metal, or injurious chemicals; (2) by revision of the process of work, by redesign of tools and machines, by rearrangement of machines and other plant equipment; and (3) by rules of work, by supervision, training and education in safe practices of workmen and foremen.

ADDENDUM TO ARTICLE ON HUGH HUGER TOLAND

(See Page 353)

LIST OF THE CLINICAL CONTRIBUTIONS OF HUGH HUGER TOLAND, M.D. (1806–1880)

On the Reproduction of Bones, Pac. M. and S. J., 1:6, 1858.

Gunshot Wounds—Resection of the Elbow-Joint—Amputation—Death from phthisis pulmonalis, *Idem.*, page 70.

Veratrum viride — American Hellebore — Indian-poke, *Idem.*, page 103.

Vesicovaginal Fistula—Operation and Cure—Two Cases, *Idem.*, page 128.

Ligation of Femoral Artery for Popliteal Aneurysm, *Idem.*, page 170.

Two Cases of False and One of True Aneurysm of the Popliteal Artery, *Idem.*, page 178.

Two Cases of Exsection of the Ribs, and the Removal of Foreign Bodies from the Chest, *Idem.*, page 217.

Case of Fracture of the Cranium, and the Existence, During Nine Months, of Foreign Bodies in the Substance of the Brain—Operation—Cure, *Idem.*, page 259.

Haemastatics, The Use of Monsel's Solution in Three Cases, *Idem.*, page 266.

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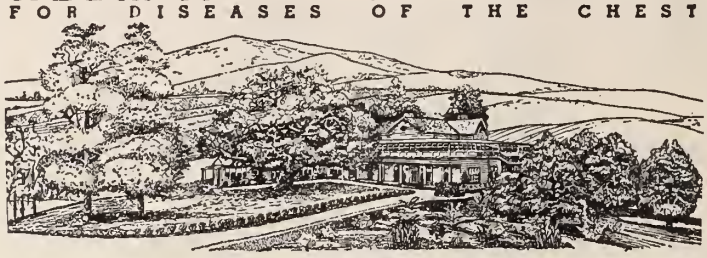
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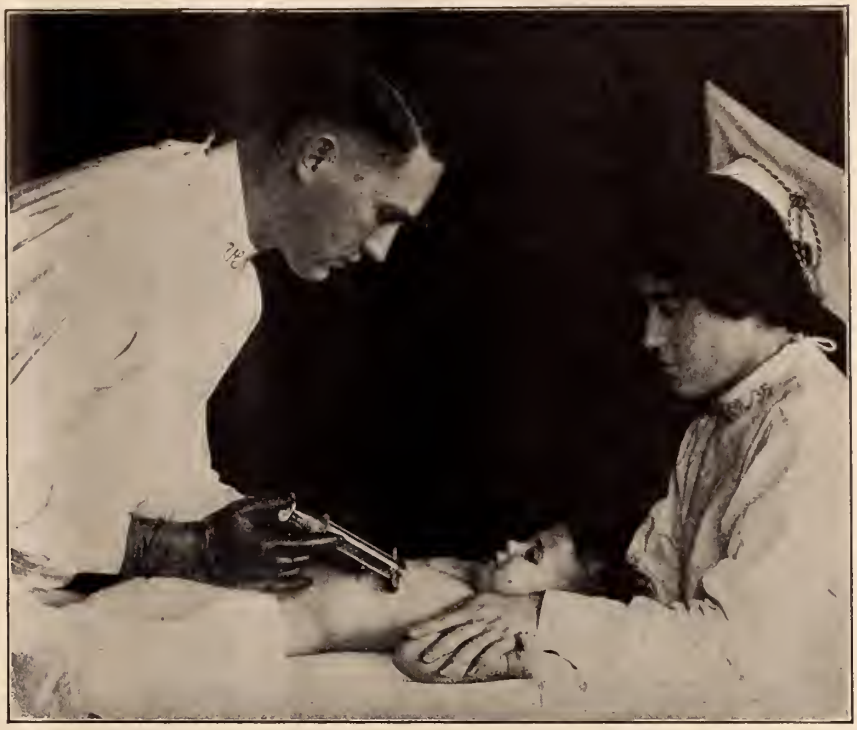


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E. T. Remmen	Glendale	1940
Junius B. Harris (Chairman)	Sacramento	1941
President ex officio		
President-elect ex officio		

Committee on Scientific Work

F. M. Pottenger	Monrovia	1939
Lemuel P. Adams	Oakland	1940
J. Homer Woolsey	Woodland	1941

Howard F. West, Secretary of Section on General Medicine, ex officio

Nelson J. Howard, Secretary of Section on General Surgery, ex officio

Frederick C. Warnshuis (Chairman), ex officio

Committee on Public Relations

The Committee on Public Relations consists of tbe chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is Frederick C. Warnshuis. The directer of the Department of Public Relations is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is ex officio a member of the Council.

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Daniel Crosby.....Chair., Com. on Hospitals, Dispensaries, Clinics
Morton R. Gibbons.....Chair., Com. on Industrial Practice
George D. Maner....Chair., Com. on Membership and Organization
John H. Graves.....Chair., Com. on Medical Economics
Junius B. Harris.....Chair., Com. on Public Policy and Legislation
George G. Reinle.....Chair., Cancer Commission
John C. Ruddock.....Chair., Com. on Postgraduate Activities
William W. Roblee.....President of California Medical Association
Charles A. Dukes.....President-elect
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Communications for the Public Relations Department should be addressed to the Director, Frederick C. Warnshuis, M. D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Alson R. Kilgore	San Francisco	1939
Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
George G. Reinle (Chairman)	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940
Orville Meland (Sec'y for Southern Section)	Los Angeles	1941
A. Herman Zeiler	Los Angeles	1941
Gertrude Moore	Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

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2404 Broadway, Oakland
President, Clarence A. DePuy, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society
President, Raymond Kilduff, 322½ Meyers Street, Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Selby H. Marks, Grabstein Bldg., Pittsburg.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
President, Henry A. Randel, Box 2308, Fresno.
Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Francis M. Stump, Crescent City.
Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Henry B. Graeser, 115 E. Fifth Street, Holtville.
Secretary, William A. Clarke, Holtville.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, Harry W. Lange, Hopkins Bldg., Bakersfield.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8 p.m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, George H. Kress, 945 Roosevelt Bldg., 727 W. 7th St., Los Angeles.
Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, W. Scott Polland, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Charles A. Craig, Lakeport.
Secretary, Robert B. Smalley, Willits.
Meeting, *On Call.*

Merced County Medical Society
President, E. M. Soderstrom, Merced.
Secretary, Fred O. Lien, Shaffer Bulding, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Curtis B. Gorbam, 215 Franklin Street, Monterey.
Secretary, Harold R. Lusignan, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Walter Rapaport, Imola.
Secretary, M. M. Bootb, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, G. Wendell Olson, 211 No. Pomona St., Fullerton.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. Ettrick Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, D. D. Roos, Corona.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Dave Dozier, California State Life Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Delbert B. Williams, 401 Nortb Eighth Street, Colton.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, Bryant R. Simpson, 1205 Medico-Dental Building, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William C. Voorsanger, 490 Post St., San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, A. C. Boehmer, Box 306, Lodi.
Secretary, George H. Robrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Frederick R. Mugler, 1170 Marsb Street, San Luis Obispo.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

San Mateo County Medical Society
President, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, E. J. Lamb, 1515 State Street, Santa Barbara.
Secretary, J. Jerome Rupp, 16 E. Junipero Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, E. O. G. Scbmitt, 608 Medico Dental Bldg., San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, Dean S. Woodard, Stoesser Bldg., Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
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Secretary, Morton J. Murphy, Shasta County Hospital, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
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Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Second Sunday.*

Solano County Medical Society
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Secretary, Jobn W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Alfred A. Thurlow, 505 B St., Santa Rosa.
Secretary, C. M. Carlson, 534 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
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Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Tbompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, E. R. Zumwalt, Tulare.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

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President, Grundy C. Coffey, Bank of America Building, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Cbarles S. Roller, Woodland Clinic, Woodland.
Secretary, W. J. Blevins, Jr., Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society
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Meeting, *Second Tuesday.*

(Roster lists continued on advertising page 6)



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We would find a man to come to you to do gladly the things you call *beginners'* tasks; tasks that take your years and make them *less* than you would make them; tasks that give *him* skills and poise and judgment that come only from doing.

The plan would give you TIME . . . *years* . . . to do with as you will . . . to lengthen life, to make it sweeter, to make it give the *greater* things. . . .

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Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building, San Francisco.

California Northern District Medical Society

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Los Angeles, 906 State Building.
Sacramento, 420 State Office Building.
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Secretary, C. B. Pinkham, Room 512, 450 McAllister Street, San Francisco.

Southern California Medical Association

President, Franklin R. Nuzum, Cottage Hospital, Santa Barbara.
Secretary, Robert W. Langley, 1002 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read. San Francisco office, 450 Sutter Street. Los Angeles office, Room 563, 1151 South Broadway.

Better Health Foundation

President, Reginald Knight Smith,* 490 Post Street, San Francisco.
Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco.
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Laryngoscope, 1937, XLVII, 58-60 ☐

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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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Caustic Poisons.—In Washington, D. C., four hardware dealers sold hydrochloric (muriatic) acid in discarded whisky and gin bottles . . . without relabeling and with the original labels intact. Although it is a common practice to sell small quantities of poisonous and nauseous liquids from a larger container in such discarded bottles without relabeling or removing the old label, the Federal Food and Drug Administration reminds that it is a dangerous and, in some places, an illegal practice.

Hydrochloric acid, for example—used for removing stains from such surfaces as brick, tile or porcelain—is a deadly poison if taken internally. Commercial hydrochloric acid is a transparent, yellow, corrosive liquid. It is not hard to imagine, says the Administration, what might happen if the purchaser, forgetting that the label no longer applied, or a member of his family or a friend taking the label for granted, chanced to use the contents of one of these bottles. The symptoms of hydrochloric acid poisoning do not make pleasant reading.

The Food and Drug Administration prosecuted these four cases, because it has local jurisdiction in the District of Columbia in enforcing food, drug and insecticide laws, including the Federal Caustic Poison Act which covered these cases. It has not jurisdiction over retail sales generally, but cites these as practical examples of an all too common custom of selling dangerous and nauseous liquids in discarded beverage bottles.

Food and Drug Administration officials also warn dealers of the heavy risks they run in selling destructive chemicals in discarded beverage bottles. A tragic mistake by a careless customer might let a dealer in for a series of criminal and civil actions disastrous to his business and his bank account, whether he won or lost.

The Federal Caustic Poison Act covers the following caustic or corrosive substances or mixtures containing as much or more than the percentage noted: Hydrochloric, sulphuric, and oxalic acids, 10 per cent; nitric and carbolic acids, 5 per cent; acetic acid, 20 per cent; any salt of oxalic acid, 10 per cent; hypochlorous acid or its salts, except chlorinated lime to yield available chlorine, 10 per cent; potassium hydroxide, 10 per cent; sodium hydroxide, 10 per cent; silver nitrate, 5 per cent; and ammonia water, 5 per cent.

Some states and cities, but by no means all, have comparable laws governing retail sales. The Federal Act does not cover retail sales from bulk containers, except in the District of Columbia and the Territories of the United States, but does cover sales in containers when the goods cross a state line or are offered for importation into the country. The Caustic Poison Act does not require more than local laws should, to be effective. This act requires adequate and conspicuous labeling of the poison including the common name, the word "poison," and antidote and directions for treatment. The label must also give the name of the manufacturer, packer, seller, or distributor.

There are a number of other products, either poisonous or nauseating, that are often retailed from bulk goods and enter the home in discarded beverage and other small containers with the original labels intact. Reports of mortality records show that kerosene and gasoline are responsible for many child deaths. A fatal dose of these substances for a child is in the neighborhood of one or two tablespoonfuls. Other products that may be mentioned are some antifreeze mixtures, turpentine, cleaning mixtures and solvents, lubricating oils, insecticides, and denatured alcohol.

Through the efforts of the American Medical Association and other interested persons and organizations, Congress passed the Federal Caustic Poison Act on March 4, 1927, for the purpose of insuring the use of poison labels on certain dangerous caustic or corrosive products and thus putting users on their guard. Enforcement of the act was assigned to the Food and Drug Administration.

Ill health is now bad business. It is possible, by applying the public health knowledge we now have, to cut down greatly the economic losses by preventable diseases. It is far less expensive to control these diseases than to continue to pay tax money, charity, and insurance dollars for the needlessly sick and premature dead.—Parran.

Immunize now for effective control of

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In the *treatment* of ivy poisoning, "Poison Ivy Extract *Lederle*" has at times performed most spectacularly. A single injection often gives marked relief within 24 to 48 hours. A second injection 24 hours later may be required; this has an added value in its probable preventive effect in case of later exposure. A third injection is rarely necessary.

Results of Experiment in C. C. C. Camps in 1935

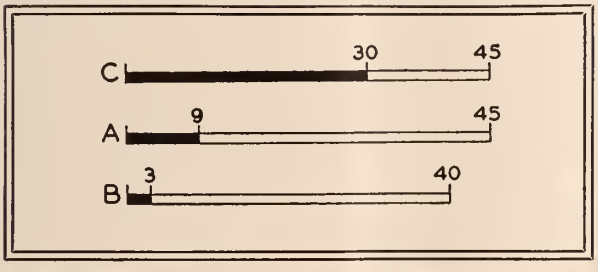


Chart shown at left covers a 6-week period following the first prophylactic dose. One hundred and thirty men were divided into three groups: A, B, C. All intermingled in their work in clearing ivy-infested areas.

Group C received no previous injections.

Group A received four weekly injections of 1/12 regular dose of "Poison Ivy Extract *Lederle*."

Group B received four weekly injections of the regular dose of "Poison Ivy Extract *Lederle*."

The shaded areas represent the number of exposed men affected with ivy dermatitis in the 6-week period.



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Social Security Board General Relief.—In telegraphic reports from thirty-five states and the District of Columbia for 107 cities show a negligible increase in the number of cases receiving general relief, and a decrease of 1 per cent in the amount of obligations incurred from February to March, according to figures made public by the Social Security Board today. In slightly more than half of the 107 urban areas there was a decrease in the number of cases receiving general relief. Although thirty-three of the cities showed decreases ranging from 1 and 10 per cent, seven showed decreases of more than 20 per cent, and fourteen others of between 10 and 19 per cent. Increases in case load amounting to more than 10 per cent occurred in only fourteen of the cities, and in only three cities the increase was as much as 20 per cent. In thirty-two cities there were small increases of between 1 and 9 per cent.

There were increases in the obligations incurred in more than half of the urban areas. In forty-three the increase was small, not exceeding 10 per cent; in only six the increase was as high as 20 per cent. Decreases not exceeding 10 per cent in the obligations incurred were reported for thirty-three cities. In two cities there were decreases of more than 50 per cent, and in eight others 15 per cent or more. With a few exceptions, the largest increases were in the East.

General relief, it was explained, includes all state and local relief in cash and in kind extended to the needy, except public assistance to the needy aged, needy blind, and dependent children under the Social Security Act, other public assistance of these special types, and aid to veterans under state and local statutes. It does not include costs incurred for services such as maternal and child health and welfare services, or costs of hospitalization, burials, or institutional or boarding-home care of children; nor earnings under the Works Program, loans and subsistence grants made by the Farm Security Administration, or Federal surplus commodities. Voluntary reports on costs and number of cases of general relief in urban areas are telegraphed to the Social Security Board each month by state agencies.

Following is a summary of the reports on relief for 107 urban areas for March, 1938:

Urban Area	Cases Receiving General Relief: Number of Cases	Cases Receiving General Relief: Percentage Increase (+) or Decrease (—) from February	Obligations Incurred for General Relief Extended to Cases: Amount of Obligations	Obligations Incurred for General Relief Extended to Cases: Percentage Increase (+) or Decrease (—) from February
Total for 107 urban areas	962,430	(2)	$27,830,646	—1
California				
Los Angeles	50,527	+6	1,641,283	+2
Oakland	12,483	—1	354,612	+2
Sacramento	3,411	—1	81,961	—9
San Diego	4,908	+6	144,473	+2
San Francisco	16,989	+4	468,208	+2

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

J. B. Murphy. Stormy Petrel of Surgery. By Loyal Davis, M.D., M.S., Ph.D., Professor of Surgery and Chairman of the Division of Surgery in Northwestern University. Cloth. Pp. 311. Price, $3. New York: G. P. Putnam's Sons, 1938.

Essentials of Obstetrical and Gynecological Pathology with Clinical Correlation. By Marion Douglass, M.D., F.A.C.S., Assistant Professor of Gynecology Western Reserve University, and Robert L. Faulkner, M.D., Senior Clinical Instructor in Gynecology Western Reserve University. Cloth. Pp. 187, with 148 illustrations. Price, $4.75. St. Louis: The C. V. Mosby Company, 1938.

BOOK REVIEWS

Essentials of Obstetrical and Gynecological Pathology. By Marion Douglass, M.D., and Robert L. Faulkner, M.D., Western Reserve University. Cloth. 187 pp., 148 illustrations. Price, $4.75. C. V. Mosby Company, St. Louis, Missouri.

An excellent text for students where clinical records are correlated with the pathology that is present. This is accomplished by descriptive text and illustrations. Gross and microscopic specimens are shown.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 480)

improvement cannot come by just sitting back and paying no attention to what is going on and ignoring those who are helping you. Think it over.

* * *

A Physician's Telephone Exchange.—In the *Journal of the American Medical Association* for April 12, there is an editorial with the above title which begins with this sentence: "In some respects, Europe is a little ahead of us." This is said in connection with a few words descriptive of physicians' telephone exchanges in Vienna and Berlin, and possibly elsewhere. There has been one such exchange in San Francisco for a number of months, and we understand that one has been started in Los Angeles and another is to be started in Oakland. . . .

* * *

Oliver D. Hamlin, M.D. (President, 1912-1913).—Doctor Hamlin was born in Alameda County, California, April 1, 1870. After going through the public schools, he entered Santa Clara College, graduating in 1890. In 1891 he entered Cooper Medical College of San Francisco, and was graduated from that institution in 1894. He began active practice immediately as resident physician of the Southern Pacific Hospital in Oakland on January 1, 1895.

* * *

President's Address. By O. D. Hamlin, M. D., Oakland. In considering the relation of medicine to the whole people, we find a most peculiar and anomalous condition. Never has scientific medicine been called upon by governments, by communities, by the thinking element of the people, for such monumental services, for such distinct advances, as during the past few years and at the present time. On the other hand, never has the art of the practice of medicine by the average practicing physician been in such disrepute. Medical science, as found in the research laboratory, the high-class teaching hospital, the properly equipped and up-to-date medical school, is in a unique position of official respect and individual admiration; medical practice of the everyday sort seems to be the storm center of a riot of attacking, warring fanatics. The two classes of medical effort seem to be occupying the extremes of favorable and unfavorable public recognition. . . .

(Continued on Page 15)



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Hutchison & Hunter: Clinical Methods	4.50
Kronfield: Introduction to Ophthalmology	3.50
Menninger: Man Against Himself	3.75

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Since 1912

TWENTY-FIVE YEARS AGO

(Continued from Page 13)

From Report of the Secretary and Editor.

To the President and Delegates:

Membership.—At the close of 1911 there were 2,118 members of the State Society; at the close of 1912 there were 2,278 members, an increase of 160 during the year 1912. . . .

From Report of the Council.

To the President and Delegates:

As chairman of the Council I appear before you for the eleventh time to present our annual report. At the session of 1902 the present form of our organization was adopted, and the House of Delegates and the Council, as governing and directing bodies, were created. The first meeting of the Council was held on July 18, 1902, and the sixty-eighth meeting was held on April 14, 1913; during the eleven years there has been but one meeting at which there was not a quorum present.

Our condition at present, as compared with what it was at the beginning of the work of the Council, is a matter of pride and congratulatory reflection. At the first meeting of the Council, much of our time was taken up with a discussion of whether we could or should start a journal and whether it would wreck the Society! Today this seems absurd to us, for we have seen the JOURNAL, under the management of Doctor Jones, grow steadily till it paid its way, and then keep on growing till now it pays a handsome profit—a larger actual profit than any other state journal published. And I presume to call your attention to the fact that the very first number of our JOURNAL, at Doctor *Jones's* instigation, started the fight against nostrums and dishonest proprietary remedies, and that the policy of clean advertising which was then established by your editor and your publication committee and endorsed and approved by your Council set an example which was later followed by the *Journal of the American Medical Association* and by a number of state journals and a few privately owned journals. It took a good deal of faith and confidence, and a great deal of hard work to pull through the early years, for we began with a handful of members and less than $800 in money. . . .

Medical Defense.—The most important matter of business now engaging the attention of the Council is the Medical Defense feature of our work. . . .

From Minutes of the House of Delegates of the Medical Society of the State of California.—Forty-Third Annual Session, Oakland, April 15, 16, 17, 1913.

First Session

The first session of the House of Delegates was called to order by the President, O. D. Hamlin, at 8 p. m., Tuesday, April 15.

Reference Committee on Reports and New Business. On motion of Kress, seconded and carried, a committee of three was appointed to consider all reports of officers and committees and to report to the House with recommendations at the second session. The President appointed as such committee, George H. Kress (chairman), G. G. Reinle, and Rene Bine. . . .

Second Session

Wednesday, April 16, 1913

The House of Delegates was called to order at 8:20 p. m. and the roll call disclosed the presence of fifty-six delegates.

Place of Next Meeting. Riverside and Santa Barbara were nominated and the President declared a ballot and for that purpose appointed F. B. Carpenter and Sol Hyman as tellers. Riverside received twenty-nine votes and Santa Barbara received thirty-five votes; the President announced the choice of the House as Santa Barbara.

(Continued on Next Page)



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AMNESIA

Convenientia Patientis

DIAGNOSIS: Loss of memory, usually following purchase of goods or professional services.

SYMPTOMS: Avoids the creditor; moves, leaving no forwarding address; ignores bills, statements and letters; or discovers treatment was unnecessary, or ineffective, or both; charges excessive, as neighbor got more for less from another; can't afford to pay, as must pay chiropractor who cured, and paying on new automobile.

PROGNOSIS: Usually curable in early stages; if neglected, is progressive and becomes chronic and incurable.

℞ **PRESCRIPTION:** Refer promptly when ailment discovered to competent collection specialist (Cramer Collection Service).

TREATMENT: (Administered by the C. C. S.): Tactful approach; courteous, but firm and effective argument; increase and repeat for satisfactory result.

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DISCUSSION: (By the C. C. S.): Unnecessary and unwise delay in proper use of suggested prescription results in **rigor mortis** of the bill.

▼

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

President. Fitch C. E. Mattison was placed in nomination by H. Bert Ellis. There being no other nominations it was moved, seconded and carried, that the Secretary cast the ballot of the House; this was done and the President declared F. C. E. Mattison elected President for the ensuing year.

First Vice-President. Barton J. Powell was nominated and there being no other nominations the Secretary was instructed to cast the ballot, which was done.

Second Vice-President. George Tucker was nominated by F. B. Carpenter, and on motion he was unanimously elected by a rising vote.

Secretary. Philip Mills Jones was nominated and there being no other nominations, on motion, the President was instructed to cast the ballot of the House, which was done, and Philip M. Jones declared elected.

All of the following officers were elected on a motion in each instance that the Secretary cast the ballot of the House:

Councilors—Second District, George H. Kress; Sixth District, C. G. Kenyon; Eighth District, James H. Parkinson; At Large, O. D. Hamlin.

Committee on Public Policy and Legislation—Two to serve for three years: F. F. Gundrum, Sacramento, and T. C. Edwards, Salinas.

Committee on Scientific Work—To serve four years: A. B. Grosse.

Committee on Arrangements—Rexwald Brown, Benjamin Bakewell, and Gilbert Hamilton.

Committee on Public Health—C. C. Browning, John C. King, W. F. Snow, G. F. Broderick, and N. K. Foster.

Delegates to the American Medical Association for two years: George Hare, Fresno, and V. G. Vecki, San Francisco.

Alternates for one year: Clarence Moore, Lem Adams, and Emmet Rixford. . . .

From Report of the California State Tuberculosis Commission by George H. Kress, M.D., Los Angeles, Chairman.—The California State Tuberculosis Commission came into being two years ago as a result of the passage by the Thirty-ninth California State Legislature of a bill appropriating the sum of $5,000 to be expended in carrying on an investigation concerning the prevalence, prevention, and treatment of tuberculosis in California. The bill provided, furthermore, that this investigation should be conducted under the supervision of a state tuberculosis commission to be appointed by the California State Board of Health.

The Commission as thus appointed consisted of an executive committee of five members and an advisory board of fifty members. The full membership consisted of physicians, legislators, sociological experts and other laymen, who had had special opportunities or reasons for being interested in the solution of the tuberculosis problem of California. The above members all served without pay or salary. A secretary, Mr. Guy P. Jones, was employed to collect and analyze the morbidity and mortality statistics of the state. . . .

It may not be out of place here, however, to enumerate the special bills prepared under the direction of the Commission and which are now before the present Legislature for consideration.

These are:

1. A Division of Tuberculosis under the State Board of Health with an appropriation of $20,000 for the two years, 1913 and 1914.

[Senate Bill No. 980, introduced by Senator Mott, and the companion Assembly Bill No. 1234, introduced by Assemblyman Guill, provide for this.]

2. A Revolving Fund for the use by the State Board of Health in providing immediate assistance to emergency or otherwise specially urgent cases; the respective counties

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responsible for such cases to be required to reimburse the revolving fund for all sums expended from it.

[Senate Bill No. 984, introduced by Senator Birdsall, and the companion Assembly Bill No. 1385, introduced by Assemblyman Dower, make such provision.]

3. State Regulation of county hospital wards for advanced tuberculosis patients and State Aid for county treatment of tuberculosis patients to the extent which may be indicated by the finances of the state.

[If funds are available for this purpose, Senate Bill No. 6, introduced by Senator Boynton, can be amended in accordance with the suggestion.]

4. State Farm Colonies for early and convalescent tuberculosis to be provided if possible.

[Senate Bill No. 1094, introduced by Senator Boynton, and the companion Assembly Bill No. 1403, introduced by Assemblyman Farwell, provided for these measures.]

5. Existing laws related to tuberculosis to be amended if necessary so as to insure their enforcement, and official recognition of dispensaries should be provided, although at the present time it is deemed expedient that they should remain supported wholly by municipal and philanthropic appropriations. . . .

From Some Original Articles:

Effects of Athletics on Young People—Subreport of H. D'Arcy Power on Psychological Aspect of the Question.—This is a résumé of a detailed paper on the subject, to be read at a general meeting of the Society, on the evening of the 15th.

In seeking an answer to the question as to how and to what extent athletics has an influence on the mind, four lines of investigation were open.

First: A deductive statement based on known physiological and psychological data.

Second: Laboratory investigations as to mental conditions before, during, and after training.

Third: A statistical investigation into the records of colleges, with the view of ascertaining the scholastic status of athletic teams as compared with nonathletes.

Fourth: A critical estimate based on the opinion of a large number of instructors, reflecting their actual observation and experience.

The conclusions here presented follow all these lines, but the chief accent has been placed on the last, to which special attention has been directed.

From an Article on "Present Status of Prostatic Surgery" by Charles D. Lockwood, A. B., M. D., Pasadena.—Every new field of surgery must pass through its formative period until sufficient experience has accumulated to permit of more or less definite conclusions as to its value, technique, and mortality. Surgery of the prostate has been no exception in this rule. The discussions have not been so heated nor numerous as those regarding appendicitis, but this is due to the fact that fewer cases demanding operation are met with and a relatively small number of surgeons have interested themselves in prostatic surgery.

From an article on "An Instance of Hypersensitiveness to Homatropin" by Douglas W. Montgomery, M. D., San Francisco.—There can be no doubt that the disturbances in this case were due to the homatropin, although we have no reports of eruptions caused by this drug. It is well known, however, that atropin and the other drugs of its class can give rise to just such eruptions, and, in the case in hand, the symptoms occurred coincidentally with the dilation of the pupil and subsided with the contraction, and they were erythematous and consequently vasodilatory, and therefore in accordance with the vasodilatory eruptions of belladonna and atropin. In fact, the patches on the skin were more characteristically vasomotor in their appearance than most of the eruptions ascribed to belladonna, as they were not alone bright red but also edematous and circular, their circularity corresponding to the terminal branches of an arteriole tree. . . .

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 480)

"She stands at advantageous points around town, where the people she cannot see will see her and, more important, see the sign her courage dictates that she wear. You've seen her—seen the sign that reads: 'Dinitrophenol Made Me Blind. Please Inquire About It! No Alms!' Her name is Mrs. Edna Gibbs and her main aim in life today is to make the public so alive to the dangers of untried drugs that it will force Congress to pass a revised Federal Food and Drug Act. To this end she suffers the gaze of the curious, stands until her feet ache and burn until the pain in her eyes forces her to go to her darkened doom. The revised law will do nothing for her—five operations have been of no avail. She has only two per cent sight in one eye. But through her work she may prevent others, particularly women, from going through life sightless. It was while she was attending University of California that Mrs. Gibbs took dinitrophenol, a reducing drug, under the prescription of a doctor. She says: 'Whenever I wanted to lose three pounds, five pounds, I took the medicine as he prescribed. In my ignorance and my trust in him, I did not realize that anything powerful enough to burn up fat in my body would burn up valuable tissues. Suddenly, one day, a thin veil came across my eyes and then, a few days later, down town, the curtain dropped. I stood there, wanting to scream, yet not being the screaming kind, completely helpless. It is a tragedy only those who know can understand! . . . She was unsuccessful in her fight to obtain revised laws for California; but during the last regular session of the legislature obtained approval of Dr. Charles B. Pinkham, Secretary of the State Board of Medical Examiners, of the provisions in AB 1235 pertaining to prescription and dispensing of dinitrophenol. . . . Mrs. Gibbs is as energetic in this educational program as she was in secretarial work before she was blinded. Since January of this year, when she began appealing to the public by making street appearances, she has distributed two thousand pamphlets throughout the state. She is financing her campaign without outside aid, at great sacrifice to herself. . . . Mrs. Gibbs, a Delphian member of long standing, has been meeting club and business women both here and in San Francisco, gaining their support of her gallant program." (Sacramento *Union*, April 10, 1938.) (Previous entries, August, September, 1934; July, August, 1935; December, 1937; March, 1938.)

"A young wife lay near death in a local hospital yesterday, victim of what authorities describe as 'a terribly bungled, illegal operation.' In the city prison, charged with performing that operation, was a former doctor, a man who made national headlines four years ago. He is Clayton E. May, Minneapolis physician who treated John Dillinger when that outlaw, newly escaped from the Crown Point jail, was wounded during the hunt for first Public Enemy No. 1. May was convicted of conspiracy and sentenced to serve a four-year term. His license was revoked. After serving his sentence he came West, has been in San Francisco almost a year. . . . Police asserted that May, assisted by a nurse who is now a fugitive, operated upon Mrs. Doris Alexander in his apartment at 444 Larkin Street on Tuesday. . . . May declared that after his release from prison he found himself disgraced, came to San Francisco, and has been living 'on a few hundred dollars I had saved.' Police reported, however, that they discovered a large quantity of surgical instruments and other professional paraphernalia in his apartment." (San Francisco *Examiner*, April 15, 1938.) No one by the name of Clayton E. May holds a license entitling him to practice any system of the healing art in the State of California.

"Superior Judge Martin I. Welsh today sentenced Lawrence P. Lorraine, forty-five year old male nurse, to Folsom State Prison for a term of two to five years as the result of the latter's conviction by a jury on a charge of abortion. . . . Defense Attorneys Horace F. Frye and Robert

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Huston gave oral notice of their intention to appeal. The court granted their request that Lorraine be permitted to remain in the county jail until next Monday to permit the disposal of certain business matters. Lorraine was convicted April 5 on a grand jury indictment charging he performed an illegal operation upon Sally Salverson, twenty-one, a night club entertainer, whose professional name is Sally Jeune." (Sacramento *Bee,* April 14, 1938.) (Previous entries, January, February, May, 1935.)

"Beware of endocreme, a cosmetic with a menace. *The Journal of the American Medical Association* this week broadcasts a warning against a widely advertised beauty product. . . . Endocreme is applied by many women to the face, neck, arms, and hands every night. The purchaser is cautioned on the label against omitting treatment for a single night if the best results are to be obtained. From many sources comes scientific evidence that serious harm may follow the persistent use of this product. It contains estradiol, a hormone. . . . Contrary to the manufacturer's claim, the substance may be absorbed from the skin and may thus exert systemic effects, says the medical journal. Endocreme is manufactured by Hirestra Laboratories, Inc., New York; it bears the approval of the Good Housekeeping Bureau." (San Francisco *News,* April 11, 1938.)

"Ernest G. Wollenweber was arrested in Dorris for practicing medicine without a license. Wollenweber claims he was a practicing physician in Keokuk, Iowa, but had not been properly authorized to practice in the State of California. The arrest was made by Thomas P. Hunter, agent for the Board of Medical Examiners of the State of California. Wollenweber was taken before Justice of the Peace George Otto, who imposed a sentence of ninety days in the county jail and a fine of $100. Under the circumstances the jail sentence was suspended and after he had paid $50 on the fine the remaining $50 was also suspended. . . ." (Yreka *News,* April 7, 1938.)

"Albert Best, forty, known to police as 'Doctor Fortune,' has been released on $500 bail pending his appearance in Superior Court in San Francisco next week on removal proceedings to return him to New York City, where he faces check charges. Police Inspector Charles Dullea protested release of Best. . . ." (Oakland *Tribune,* April 13, 1938.)

"City Attorney John J. O'Toole, of San Francisco, attacked constitutionality of the new socialized medicine plan for San Francisco's city employees today, before the California Supreme Court. O'Toole was representing City Comptroller Harold Boyd, who refused to authorize deduction from employees' salaries for the health insurance plan, first of its kind in the State. The city attorney declared the charter amendment, which set up the plan, deprived employees of a part of their salaries without their individual consent. . . ." (Oakland *Tribune,* April 9, 1938.)

"Jean Adams, forty-two, charged with posing as a doctor and treating Donna MacEachren, twenty-five, of 1646 Steiner Street, San Francisco, for a non-existent disease, pleaded guilty before Municipal Judge Frank W. Dunn today. So aroused was the jurist after hearing the evidence that he commented: 'This defendant is a menace. I suggest that additional charges be filed if evidence warrants it and if she is convicted, I will make the sentences consecutive.' Further testimony of the woman's guilt came from J. W. Williams, agent for the State Board of Medical Examiners, who posed as a patient, was examined, and then seized the woman's books and surgical instruments. . . ." (Oakland *Tribune,* April 7, 1938.) "Heavy penalties were imposed yesterday upon Jean Adams, forty-two, who pleaded guilty to two counts of practicing medicine without a license. Municipal Judge Frank W. Dunn, who displayed indignation when evidence against the woman was presented, passed this sentence upon her: A fine of $500. A

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

suspended sentence of six months. Restitution of $450 to a 'patient' she treated for a non-existent disease. An order to 'go out of business.' Joseph W. Williams, special agent for the Board of Medical Examiners, who arrested the woman, declared he had evidence that she practiced medicine extensively." (San Francisco *Examiner*, April 9, 1938.)

"The law stooped to punning here today when Judge W. F. James, ruling on litigation involving the Elysium Nudist Camp, declared it No Suit. It was a test case brought by an oil company in behalf of numerous Los Gatos merchants who delivered food, medicine, lumber and drugs to the Nudist Colony, and did not get paid. The deliveries were made while George Spray was Chief Nudist. He has since become bankrupt; the camp has become the property of Dr. E. W. Laisne of San Francisco. . . ." (The records of the State Board of Optometry indicate that Dr. E. W. Laisne operates the Progressive Optical System in Oakland, San Jose, Fresno, and San Francisco.)

"Dr. Robert T. Legge, who twenty-four years ago dreamed of building the greatest student health center in the world, is retiring this spring after seeing his dream fulfilled in the Ernest V. Cowell Memorial Hospital on the Berkeley campus of the University of California. . . ." (San Francisco *News*, April 8, 1938.)

"Charging fraudulent advertising in connection with the film, 'A Baby Is Born,' now playing at the Capitol Theatre, the American Committee for Maternal Welfare today filed action against John Doe Popkin and John Doe Ringer in an attempt to stop showings of the film. Accusation was made that people have been led to believe 'A Baby Is Born,' branded as 'sensational and revolting,' is really 'The Birth of a Baby,' moving picture film made under auspices of the committee some time ago. . . . The Committee for Maternal Welfare includes the American Association of Obstetricians, the American Association of Gynecologists, the American College of Surgeons, and the American Hospital Association." (San Francisco *Call-Bulletin*, May 9, 1938.)

"Charges against Allan Mills, Paradise, who was tried on charges of violating the State Medical Practice Act, were dismissed in Paradise justice court Saturday on request of Assistant District Attorney P. M. Barceloux. The case was tried in Paradise March 30 and 31, the jury disagreeing seven to five. Mills was charged with practicing medicine without a license, and was said to have operated a magnetronic laboratory, by which he could cure patients by 'tuning' to them on an electrical machine." (Chico *Enterprise*, May 2, 1938.)

"Caryl Warner, Attorney for Dr. Leila Northrup of Los Angeles, who was charged with practicing medicine without a license, has applied to the Superior Court for a writ of prohibition to stop Judge William E. Starkey of the Whittier Township Justice Court from trying the case of *People* vs. *Doctor Northrup*. Warner declares in his request that Doctor Northrup has not been given a speedy

(Continued on Page 22)

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Pablum Breakfast Croquettes

Beat 3 eggs, season with salt, and add all the Pablum the eggs will hold (about 2 cupfuls). Form into flat cakes and fry in bacon fat or other fat until brown. Serve with syrup, honey or jelly.

Pablum Salmon Croquettes

Mix 1 cup salmon with 1 cup Pablum and combine with 3 beaten eggs. Season, shape into cakes, and fry until brown. Serve with ketchup.

Pablum Meat Patties

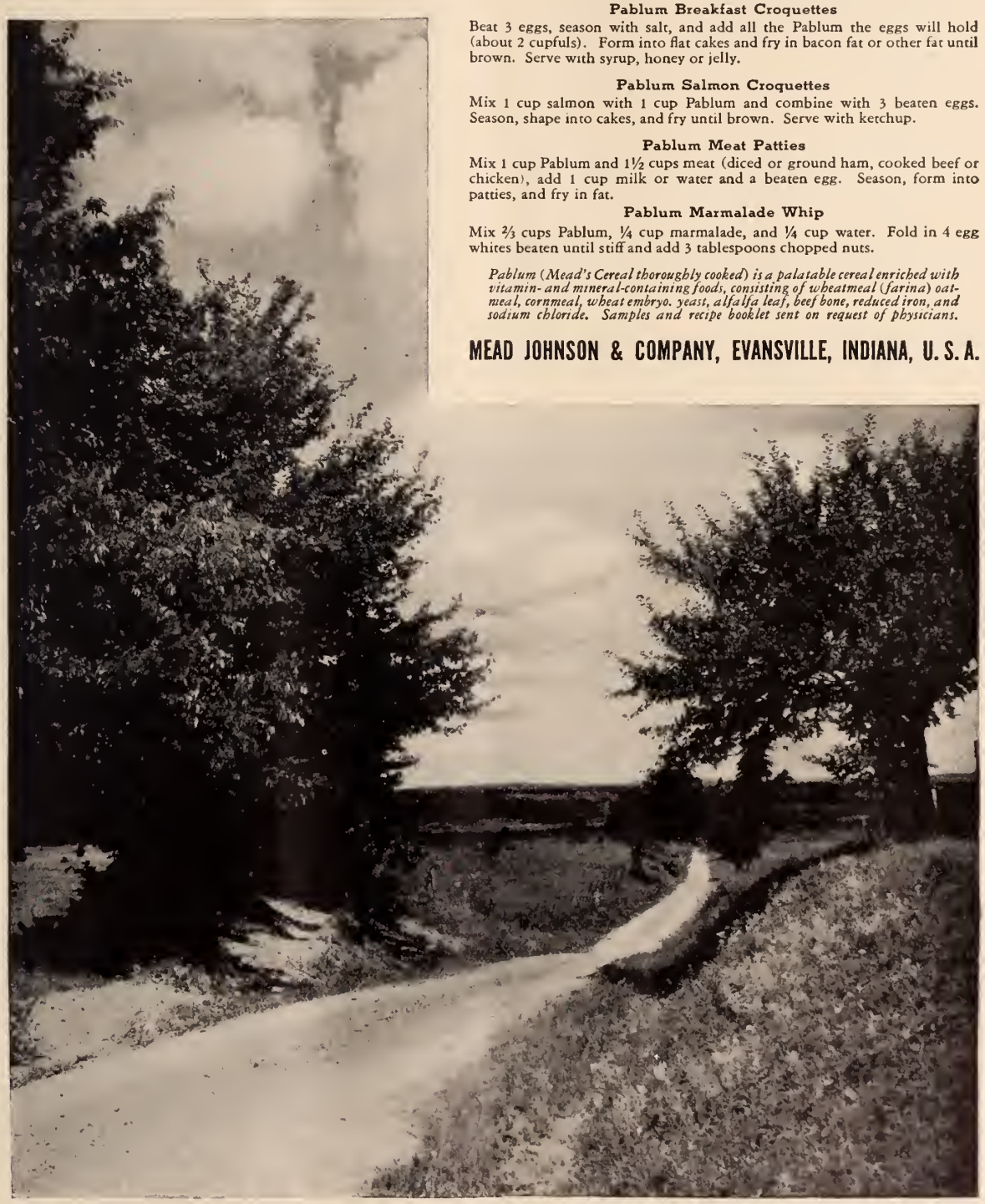
Mix 1 cup Pablum and 1½ cups meat (diced or ground ham, cooked beef or chicken), add 1 cup milk or water and a beaten egg. Season, form into patties, and fry in fat.

Pablum Marmalade Whip

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trial, which she claims she is entitled to. The Superior Court will hold a hearing on the matter May 12. Doctor Northrup was scheduled to have been tried tomorrow." (Whittier *News*, May 4, 1938.)

"Judge Frank C. Collier, after listening to testimony of five physicians testifying that Dr. Harry M. Griffith, found insane after the shooting of M. Vilas Hubbard, Pasadena banker, in 1933, had recovered his sanity sufficiently to be safely sent to the Sawtelle Veterans Hospital for care, and the testimony of Dr. Benjamin Blank, county hospital jail doctor, and Dr. E. H. Toller, of the Mendocino State Hospital for the insane, who claimed that he is still dangerously insane, found Doctor Griffith criminally insane. Judge Collier ordered the defendant recommitted to Mendocino Hospital, but granted George Carter, attorney for Doctor Griffith, a stay of ten days in which to either appeal from the decision or to ask for a further continuance. . . ." (Pasadena *Star-News*, April 7, 1938.) (Previous entry, August, 1933.)

"Charged with practicing medicine and using the title 'Dr.' without a proper license, William MacDonald, forty-one, was arrested last night by J. W. Williams, Inspector for the State Medical Board. MacDonald was released on $50 bail." (San Francisco *Chronicle*, May 4, 1938.)

"Lawrence J. Giubbini, former San Jose Chiropractor, was fined $500 in Federal Court today on a charge of failing to report income in 1934 and 1935, according to the Associated Press. Marvin Raithel, who was associated with Giubbini in San Jose, was fined $250 on a similar charge. The government charged Giubbini failed to make a report on an income of $12,439 in 1934 and $9,629 in 1935. Raithel was accused of failing to report on a 1934 income of $10,095 and a 1935 income of $4,408. Raithel now resides in Madera. Giubbini was indicted by the San Francisco grand jury in 1934 with several other persons on charges involving illegal operations, but the charge against him was dismissed." (San Jose *News*, April 9, 1938.) (Previous entries, July and August, 1936.)

"Dr. Roy E. Shipley, physician, was cleared today of charges in an indictment accusing him of participating in an 'ambulance chasing' conspiracy involving other doctors and lawyers. When the case came up before Superior Judge Frank M. Smith, a dismissal of the charge against Doctor Shipley was moved by George Stahlman, deputy



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District attorney. Stahlman said there was no evidence upon which the physician could be prosecuted." (Los Angeles *Herald and Express,* April 19, 1938.)

"Arrested on a warrant signed by Thomas P. Hunter, special agent for the California State Medical Board, Dr. Lewis Robertson, twenty-nine, and Paul A. Girard were released on $1,000 bail yesterday pending further action. The two were taken in custody at the Santa Cruz Health Institute, Front Street, by Agent Hunter and Inspector Elmer Geyer. District Attorney Ben B. Knight said the pair would be charged with violation of Section 2141 and 2143 of the State Business and Professional Code. He said he understood the two were alleged to have done chiropodist work though only possessing chiropractic licenses. . . ." (Santa Cruz *Sentinel,* April 10, 1938.)

"Abruptly resting his case at the end of prosecution testimony without offering any defense, Eugene J. Rinaldo, fifty-one year old former Board of Education candidate, yesterday was found guilty of administering medical treatment without a license in violation of the Business and Professional Code by Municipal Judge Call. Rinaldo was accused of charging Mrs. Alice M. Roche, saleswoman, $300 for administering a series of hypodermic injections of specially made medine last September in her apartment, 1275 Westchester Place." (Los Angeles *Times,* April 22, 1938.) "Dr. Eugene J. Rinaldo, fifty-one, convicted last week of practicing medicine without a license, yesterday was sentenced either to serve 180 days in jail or leave the State of California for two years. If at any time within the next two years Rinaldo returns to the State, Municipal Judge Joseph Call ruled, he must serve the full jail sentence. Rinaldo was convicted of having treated Mrs. Alice Roche for a goiter last September, for which he assertedly collected $300 in fees. He previously paid a $500 fine and was placed on two years' probation in a similar case." (Los Angeles *Daily News,* April 29, 1938.) (Previous entries September and December, 1928; February and September, 1929; September and December, 1930; June, 1931; July and December, 1932; May, July, August, 1933; February, 1934; May, 1935; December, 1936.)

"All charges against Dr. Samuel S. Bogle, former county physician. were dismissed by Judge W. D. L. Held of Ukiah in Superior Court here yesterday following approval of a settlement in which the board of supervisors and District Attorney Toland C. McGettigan agreed to accept $9,120 cash held by the former county official. The motion for dismissal was presented by McGettigan, who informed the court that counsel for both sides had agreed upon the amount assertedly due the county treasury. Doctor Bogle was indicted on charges of misusing funds placed in his care by inmates of the county hospital while he was in charge of that institution. At the time of his indictment, the physician posted several thousands of dollars in Superior Court, asking that the court determine to whom the money should be paid. The settlement, as approved yesterday, is in line with the original offer made by Doctor Bogle through his attorneys W. Finlaw Geary and C. J. Tauzer." (Santa Rosa *Press-Democrat,* April 17, 1938.)

"Attorney Louis Fursten and Samuel Sheckman were free today of conspiracy charges in connection with an alleged fake accident case." (Press dispatch, dated Los Angeles, May 3, printed in San Francisco *Call-Bulletin,* same date.)

"L. E. Dollarhide, Long Beach Chiropractor, was found guilty by a Justice Court jury of illegally practicing medicine without a license here yesterday afternoon. . . . At the same time he was acquitted on a third charge of illegally

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

advertising. . . . S. S. Hahn, defense attorney, immediately filed a motion for a new trial after the receipt of the verdicts. . . . The charges related to treatment of Mrs. Theodore Crawford of this city by Dollarhide last October. . . . It was claimed by the prosecution, conducted by Deputy District Attorney John Gabbert, that ingredients of pills sold by Dollarhide to the woman were included in materia medica, which State law does not permit chiropractors to prescribe." (Riverside *Enterprise*, April 21, 1938.)

"The twenty-seventh name was added today to the list of fatalities among women workers who painted luminous numerals on watch dials some sixteen years ago. Mrs. Margaret Laudate, thirty-eight year old mother of three children, died yesterday and an autopsy established the cause as radium poisoning. Five years ago Mrs. Laudate developed a hip ailment. By November, 1936, when her third child was born, the disease had so advanced that a Caesarian operation was resorted to in a successful effort to save her and the baby. Doctor Martland said the poison from the radium developed sarcoma in the skull. Ten years ago there were legal suits for $1,250,000 damages by a group of women who became known as the 'five radium girls.' In 1928 Federal Judge William Clark, acting as private intermediary, announced the women each would be given the equivalent of a jury verdict of $48,000. Two of the five women are alive today." (Associated Press Dispatch, dated Orange, New Jersey, May 13, printed in San Francisco *Call-Bulletin*, same date.)

"Dr. M. L. Herzig, proponent of a new system for 'purifying' the blood, was under arrest in the county jail on suspicion of practicing medicine without a license. 'Other doctors have framed me,' he charged. 'I have a patent on my method, but I have treated no one here. I was merely enlightening the world.' 'The system involves the use of electroradiation,' he said, 'in the treating of blood disorders.' Doctor Herzig claims to have saved the life of General John J. Pershing and others" (Los Angeles *Herald-Express*, May 7, 1938). The laxity of our California corporation laws is indicated by a printed circular letter dated Los Angeles, April 28, 1938, headed "University of Physicians and Surgeons of Southern California, University Hall, Second Floor, Garfield Building—Office of the President M. L. Herzig, M. D., LL. B., Sc. D.," and directed "Dear Doctor." The contents indicate an attempt to lead the public to believe that the promoter has a secret method for evading the laws regulating the practice of medicine in the State of California. Therein are found such misstatements as: "Under the present laws of this state, a student regularly matriculated in an approved university may follow unlimited practice under the tutelage of the University. . . ." The 1916 Report of the Board of Medical Examiners makes the following comment: "The office of the Board of Medical Examiners is frequently impressed with the ease with which a small group of individuals in California, at a nominal expense, may organize and incorporate under any euphonic title, with purposes as boundless as infinity, profess to teach anything without restriction, or demand as to the qualification of the so-called faculty, or without providing any facilities for instruction. . . . As a concrete example, let me present to your attention the 'United States National University, Administration Headquarters, Corner Van Ness and Turk Street. (San Francisco)—College of Attorneys and Councilors-at-Law; College of Physicians and Surgeons, U. S. N. U., M. L. Herzig, M. D., D. D., LL. D., President; Prof. A. S. Tuchler, M. D., Dean, Medical Director.' A perusal of the articles of incorporation (No. 79608) discloses . . ." that said corporation is empowered to confer almost any kind of a degree, graduate students, confer diplomas, conduct hospitals, etc. This corporation, although advertising, existed on paper only and its "campus" was said to be over a grocery. The Board

(Continued on Page 26)

WHAT EVERY DOCTOR SHOULD KNOW ABOUT

Ralston Wheat Cereal



Because sufficient pure wheat germ is added to Ralston Wheat Cereal to make it 2½ times richer in this essential vitamin than natural whole wheat . . .

Because vitamin B helps to promote normal appetite and digestion, stimulate metabolic processes, promote tonicity of the digestive tract . . . this delicious cereal is widely recommended in the diets of growing children—and for adults who require extra quantities of vitamin B. Since Ralston is an all-family cereal, its use simplifies the introduction of added vitamin B into the family diet.

Research Laboratory Report and samples of Ralston Wheat Cereal sent on request. Use coupon below.

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This year—as in past seasons—millions of people will need protection against summer discomforting glare. Many will try to buy comfort at the bargain goggle counter, not knowing that such merchandise may be actually harmful to the eyes.

Riggs has consistently restricted its "glare protection" service to optically ground and polished lenses, believing that lenses below this standard are neither safe for the patient nor acceptable to the profession.

RAY-BAN, a scientific glass for outdoor conditions, developed by Bausch & Lomb, is ready now in a series of specially designed streamline styles—in plano and for prescription ground glasses. RAY-BAN will give your patients safe and scientific protection for all their outdoor activities.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

of Medical Examiners has *vainly* tried (by legislative enactment) to remedy this deplorable condition. Reference to Corporation No. 80735 in the files of the Secretary of State shows that the University of Physicians and Surgeons of Southern California prior to October 14, 1935, was a corporation known as "Dr. M. L. Herzig, physician and surgeon." A writ of mandate brought August, 1930, by M. L. Herzig in the courts of Los Angeles (135 California Appellate, p. 41) to compel the Board of Medical Examiners to issue him a California medical license was *denied*. (Previous entries, October, 1930; January, 1934.)

Neglected Teeth.—How many days of school did your child miss this year because of illness? Was this due to toothache or some systemic condition resulting from an unhealthy mouth?

It cannot be denied that many maladies, such as sinus infections, rheumatic fever, heart disease, and others, have been directly caused or aggravated by infections which have gained entrance through neglected, unsound teeth. Knowing these things, many stand by and allow the heritage of the child, who is entitled to a sound and healthy body, to be encroached upon.

We are approaching the close of the school year and summer vacation. This affords a wonderful opportunity for checking the avoidable absences from school for next year.

Every child is entitled to receive a good education. This is the only thing which can be given and not taken from him. With competition so keen today, you should make every effort to see that all physical handicaps are removed in order that each child may have an equal opportunity.

Surprisingly true, too little attention is being paid to the child's baby teeth. Many facial deformities might have been prevented had early dental consultation been sought. Complete physical examination should include a thorough dental inspection, any and all defects should be properly taken care of. The mouth being the gateway of all nourishing material entering the body, you cannot expect that little body to grow and develop into strong healthy manhood or womanhood if no or too little care is given the mouth.

An outstanding penalty of neglect manifests itself in the loss of the first permanent molar. These teeth erupt just behind the last baby molar and, since no tooth has been lost, it is very likely mistaken for a baby tooth. These very important teeth come into place before the baby teeth are lost. They begin to form in the gums before birth and appear at about the sixth year just behind the temporary or baby molars. They replace no teeth. Being far back in the mouth, they need particular attention because of their comparative inaccessibility. Lacking daily care they are apt to become dirty and diseased, thus likely to be sacrificed.

Loss of the first permanent molars quite likely means irregular placement and strain on other teeth. Adjacent teeth tip forward and backward trying to fill the space. Incorrect jaw action leading to improper mastication of the food follows. Undue stress is put upon the teeth, which tends to produce injury to the tissue around the teeth roots. Therefore, the probabilities for pus pockets, bleeding gums, and other unhealthy conditions are greatly enlarged.

As a part of Public Health Day programs in every community, let us strive to impress upon the minds of the proper individuals the importance of mouth care. Let us start with the preschool child and instill early in its mind the necessity of visiting the dentist and from him receiving the correct advice on care of the mouth; also let us not forget that no physical examination is complete without a dental examination.—*Ohio Health News.*

Fungous Infections.—Fungous infections in man, until recently, have been one of the neglected studies of medicine. Bacteria have stolen the show! Since Leuwenhoek, in 1675, first saw microscopic life teeming in a drop of water, men have studied many microörganisms. It was not until late in the nineteenth century, however, that it was established that bacteria cause disease. Intense work has followed this discovery and today our knowledge of bac-

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teria has overshadowed medically our study of the fungi that also cause disease.

Among the fungous diseases, actinomycosis was first described in 1877 in cattle by Bollinger, and in man by James Israel. This is a chronic infectious disease in cattle, sometimes transmitted to man, characterized by the formation of lumpy tumors on the jaws and tongue. The disease is attended by loss of strength and weight and by hectic fever, and the fungus may develop in the viscera, bone, and skin, as well as in the mouth and jaws. Because of its frequent development in the lungs it was confused with tuberculosis.

Comparatively little more was known of the fungi that cause disease until Gilchrist described the rôle played by the Blastomycetes and similar fungi in certain diseases of the skin. By these investigations, however, the study of the parasitic fungi was opened and has disclosed the causative factor of many diseases whose true cause has hitherto been unknown.

Recently we find much concerning the fungi in medical literature and have come to know that the parasitic fungi can gain access to every system of the human body; that the diagnosis after their invasion may be simple but is extremely difficult in many cases and that often treatment is of little avail if not started promptly.

Industrial physicians are well acquainted with the ravages caused by fungi. One need only to consult their writings to find many cases. Blastomycosis, already mentioned here, is quite frequently seen in paper workers. Aspergillosis, a condition also called "wheatena," is seen in agricultural workers who handle grain. It is also seen in French pigeon growers. This disease is characterized by multiple small abscesses in the lungs. When these heal and x-ray pictures are taken, they are sometimes mistaken for the nodules found in silicosis. Sporotrichosis, a disease characterized by refractory abscesses under the skin, is seen in gardeners and malt handlers. This disease may become generalized and attack the muscles, bones, joints, and mucous membranes. Herdsmen and farmers, as has been mentioned before, may contract actinomycosis from the cattle they tend.

Fungous infection of the skin, next to the common cold, is the most common disease that affects mankind. Rare indeed is the person who has traveled from birth to the grave who at some time in his life has not suffered from ringworm. Doctor Legge and his coworkers found that, of 3,105 freshmen entering the University of California, 51.5 per cent of the men and 15.3 per cent of the women were infected with ringworm of the feet (Epidermophytosis interdigitalis). These figures rose to 78.6 per cent of the men and 17.3 per cent of the women at the end of the first semester.

Scales of the hair and scales falling from infected feet are capable of transferring this disease. Surprising as it seems, the organisms actually multiply on such material as hair, wool, feathers, and silk after they are deposited there. Keeping this in mind it is easy to understand that the bare feet should never come in contact with any substance that may have been contaminated by someone who has the disease. The best way to avoid this is to:

1. Always wear bath shoes when walking in public shower rooms, and bedroom slippers in strange rooms such as hotel rooms. 2. When using public showers, if slippers are not available, step on heavy newspaper or a towel when bathing, and likewise when drying the feet. 3. Gymnasium clothes should be of cotton, as woolen clothing favors the growth of the organisms. 4. If you become infected, do not try home remedies but see your physician, as the disease is stubborn and requires expert attention.

Nutritive Value of Proteins of Nuts and Beef.—Mitchell and Beadles assessed the protein value in nutrition of English walnuts, cashew, almond, filbert, and Brazil nuts, as compared with beef protein. The nutritive values of the proteins of these nuts were studied by determining the nitrogen intake and outgo of rats under conditions standardized so that significant biologic values could be estimated. They found that while the biologic values of the other nuts fall within the range of from 50 to 60, the cashew nut possesses a value of 72, only slightly below that of beef round, 76.—*Journal of Nutrition.*

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New Social Security Form Greatly Reduces Work for Employer and the Government.—A marked reduction in the number of employer reports required by the Treasury Department in connection with the administration of Federal old-age insurance will be effected through a new form which combines tax returns and wage reports. the Social Security Board announced today. The new form not only simplifies the reporting required of employers but helps the Government in its record keeping.

The new quarterly form, known as SS-1a, takes the place both of the monthly tax return and of the six-month information return previously filed by employers for 1937. On this one form, employers will hereafter report all the information previously given on monthly tax returns, Form SS-1, and six-month information returns, Forms SS-2 and SS-2a. Payment by employers of their taxes and their employees' taxes will be made quarterly when the new Form SS-1a is filed.

Under the Federal old-age insurance system, employers are required to report each employee's name, account number, and wages. This information is transmitted by the Bureau of Internal Revenue to the Social Security Board, where it is recorded in a social security account maintained for each employee for use in figuring the amount of the employee's old-age insurance benefits.

The first return on the new form will be filed in April. The return will be for January, February, and March, and must be filed with local collectors of internal revenue not later than April 30 to avoid a penalty for late filing. Other quarterly returns for 1938 on this form will be due on or before July 31, October 31, and January 31, 1939.

The new method of reporting was worked out by the Bureau of Internal Revenue and the Social Security Board to simplify the work of employers in reporting. The board pointed out that this is especially important for operators of small establishments who usually do their own bookkeeping. Returns for 1937 from over 1,700,000 employers showed that about 95 per cent had twenty or less employees. Many had only one or two employees. With this method of reporting, tax returns and wage reports will be made out at the same time. On the new form, employers will list each employee's wages for the quarter. The total of wages paid to all employees can be quickly determined, and the amount of taxes can be easily computed from this total.

The new form provides space for reporting the wages of twenty employees. For employers who have more than twenty employees a continuation sheet, known as Form SS-1b, is provided. Employers who have not received Form SS-1a or who find they need the continuation sheet can obtain these forms from local collectors of internal revenue.

Simplification of the Government's work will result from use of the new form, since tax returns and wage reports will cover the same period and be filed on the same form, and, thus the two reports must agree. The work of checking tax returns against wage reports by the Bureau of Internal Revenue will be lessened, and correspondence with employers to reconcile differences will be practically eliminated. This will enable the Bureau of Internal Revenue to transmit wage reports to the Social Security Board promptly, and posting of employee's wages to their accounts will be expedited.

Health Creed.—"My body is the temple of my soul." Therefore:

I will keep my body clean within and without.

I will breathe pure air and I will live in the sunlight.

I will do no act that might endanger the health of others.

I will try to learn and practice the rules of healthy living.

I will work, rest, and play at the right time and in the right way, that my mind may be strong, my body healthy, and that I will lead a useful life and be an honor to my parents, to my friends, and to my country.—*Bulletin of the Massachusetts Board of Health.*

IN COMPLAINTS OF FATIGUE

It May Be Lack of Food Energy

PROPERTIES OF KARO

Uniform composition
Well tolerated
Readily digested
Non-fermentable
Chemically dependable
Bacteriologically safe
*Non-allergic
Economical

*Free from protein likely to produce allergic manifestations.

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COMPOSITION OF KARO

(Dry Basis)

Dextrin	50%
Maltose	23.2%
Dextrose	16%
Sucrose	6%
Invert sugar	4%
Minerals	0.8%

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KARO EQUIVALENTS

1 oz. vol.	40 grams 120 cals.
1 oz. wt.	28 grams 90 cals.
1 teaspoon	15 cals.
1 tablespoon	60 cals.

Normal children frequently complain of fatigue. Careful study reveals that they do not consume enough food to provide them with necessary energy requirements, half of which are derived from carbohydrate.

The energy supply should be in the form which is easily digested, not readily fermented and which does not affect the appetite for other foods. Karo meets all these requirements.

Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.



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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BALTIMORE, MARYLAND

Filled Milk.—The Food and Drug Administration of the United States Department of Agriculture warns that it will institute legal action against all interstate shipments of any product falling within the statutory definition of filled milk.

The warning follows the recent decision of the United States Supreme Court in the case of *United States* vs. *Carolene Products Company*, which upheld the Federal Filled Milk Act of 1923 as constitutional.

By its terms the Filled Milk Act prohibits the interstate distribution of any combination of milk, cream, or skimmed milk, with any fat or oil, other than the milk fat so as to resemble or imitate milk or skimmed milk in any form. The legislation was enacted after a Congressional hearing. Congress determined and declared: "That filled milk, as herein defined, is an adulterated article of food injurious to public health and its sale constitutes a fraud upon the public."

The indictment in the Carolene case alleged the unlawful interstate shipment of "Milnut" and "Carolene" manufactured by Carolene Products Company of Litchfield, Illinois. Analyses by the Food and Drug Administration showed the products to be composed essentially of evaporated skim milk and cocoanut oil in semblance of evaporated whole milk. After prosecution was started, the manufacturer filed a demurrer to the indictment on the ground that the act was unconstitutional. The demurrer was sustained by the Federal Court for the Southern District of Illinois. The United States appealed to the Supreme Court of the United States which upheld the Filled Milk Act as constitutional.

Everyone should order his daily life so as to have some leisure, for it is during such parts of the day that many important decisions are made. Then a man has time to think quietly and to do some of the things, like reading, that make for his mental growth. If work tends to get him into a rut, leisure lifts him out again. If work is not carrying him to a proper goal, it is often during leisure that he discovers the fact that directs his course anew.



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A few accommodations as low as $25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

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Fitness for Parenthood.—To be parentally fit means to be physically fit, free from disease and prepared for responsibility. Now we find that it means something more. The parents must also be physiologically fit.

The strongest babies are those who most successfully resist the forces of death during the first month of life. Such babies are born to fathers aged twenty-five to twenty-nine years. The best age for mothers is shown in the following table:

First births to mothers aged	21–26
Second births to mothers aged	23–28
Third births to mothers aged	24–29
Fourth births to mothers aged	26–31
Fifth births to mothers aged	28–33
Sixth and seventh births to mothers aged	29–34
Eighth and ninth births to mothers aged	32–37
Tenth and later births to mothers aged	36–41

These are some of the findings presented by Jacob Yerushalmy, Ph.D., of the Division of Maternity, Infancy, and Child Hygiene, New York State Department of Health, to the American Statistical Association at Atlantic City recently. The discovery that the babies of very young mothers are subject to a special risk suggests to Doctor Yerushalmy a new method of public health service. Health officers might obtain from the marriage records the names of girls married in their teens and keep them under observation so that they may be advised to consult their physicians about prenatal care on the first signs of pregnancy. Such a program is further justified by the observation that first-born babies are more likely to die than second born.

Mothers who are older than the schedule limits and mothers who have had a large number of babies also deserve special care.

The Neonatal mortality rate for first births was 32.2 per 1,000 live births; for second births it was 26.1. After that the rate began to rise again until for tenth and later births it was 54.2.

The corresponding rates for premature births were 329.4 for first births, 389.6 for second births and 644.4 for tenth and later births. This shows that a baby born prematurely is far more likely to die than is a baby born at the proper time and justifies the campaign now being undertaken to give special care to premature infants.

Premature births were found to be more frequent in urban than in rural communities. However, the mortality among the premature is higher in rural areas.—"Health News." New York State Department of Health.

Hazards at Home.—A serious injury to you at home would cause wage and other losses to you and your family. Be careful of all home hazards, including the following:

1. Slippery floors and sidewalks.
2. Defective ladders and all makeshift supports.
3. Objects left lying on floors, walks, stairways, etc.
4. Broken or loose stair-treads; torn or loose stair carpet; stairs without handrails.
5. Electric lamps, extension cords, wall plugs, lamp sockets and switches in bad condition.
6. Never touch a light switch and some grounded object, such as a kitchen sink or a bathroom fixture at the same time. You might receive a serious electric shock.
7. It is dangerous to approach a gas leak with an open flame. Call the gas company. If the leak seems serious, shut off the gas at the meter.
8. Never use gasoline or naphtha for cleaning purposes; use only noninflammable cleaning fluids.
9. It is dangerous to carry scalding water about the house in open pails.
10. Always open the garage doors wide before starting the automobile engine.—Safety Instruction Card No. 129: National Safety Council.

PERSUASION may be ever so forceful, but experience alone engenders true confidence. The Lilly Research Laboratories have reason to be glad that the doctor's memory is long, that his judgment is based on results, that his confidence in therapeutic agents depends on fact and not on hearsay. Between the medical profession and Eli Lilly and Company there exists a bond of respect that is the natural outgrowth of long years of responsible dealing with each other.

Ephedrine is one of the most acceptable vasoconstricting drugs for use in the nose. As the season for "summer colds" progresses, it is helpful to remember that Ephedrine Inhalants, Lilly, have established value in relieving the discomfort of this type of nasal congestion.

Supplied in 1-ounce, 4-ounce, and 1-pint bottles.



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JUNIUS BRAINARD HARRIS, M.D.
Vice-President, American Medical Association
1937–1938

CALIFORNIA
AND
WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 48 JUNE, 1938 NO. 6

SALUTATION FROM JUNIUS B. HARRIS

OF SACRAMENTO

VICE-PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION

To Members of the California Medical Association—

Greetings:

On May 9–12, the California Medical Association held its sixty-seventh annual session at the Hotel Huntington, Pasadena, and this month in San Francisco, beginning June 13, members of our national federacy, the American Medical Association, will convene for a five-day annual session. The California Medical Association, as the constituent state unit, and the San Francisco County Medical Society will act as the home hosts. Some thoughts concerning A. M. A. membership, therefore, may be in order at this time.

The A. M. A. roster for 1938 credits the California Medical Association with 5,906 "members of the A. M. A.," but only 3,855 C. M. A. members receive the "*Journal A. M. A.*" as "Fellows of the A. M. A." It is also of interest to note that a grand total of 6,201 physicians in California receive the *Journal of the American Medical Association*, or 295 physicians more than have California Medical Association membership!

The yearly subscription price of the *Journal of the American Medical Association* is $7.00, but "A. M. A. Fellowship" also costs only that amount, and may be had by applying for the same, showing that "Fellows" of the A. M. A. receive the *Journal* without extra cost.

It is evident, therefore, that many members of the C. M. A. pay $7.00 yearly for the *Journal of the American Medical Association* alone, instead of applying for "Fellowship," while "Fellowship" is necessary for admission and participation in the scientific section of the A. M. A.

If you are a subscriber to the *Journal A. M. A.*, and not a "Fellow," we suggest that you send an air mail letter to the American Medical Association, 535 North Dearborn Street, Chicago, and ask for fellowship blanks that will permit you to become a "Fellow." It is possible that this may also be done at the A. M. A. registration booth in San Francisco. You will then be entitled to admission and participation in the scientific and other meetings of the San Francisco session.

It is the sincere hope of the officers of our national and state organizations that you will be among those in attendance at the San Francisco meetings. Preliminary announcements concerning the program, as given in the *Journal A. M. A.* of May 7, indicate a presentation of subjects of wide and important interest.

Fraternally,

JUNIUS B. HARRIS.

Medical-Dental Building, Sacramento.

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EDITOR GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in lengtb. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested tbat contributors to this Journal write to its office requesting a copy of tbis leaflet.

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EDITORIALS†

CALIFORNIA MEETINGS OF A. M. A. AND C. M. A.

Annual Session of the California Medical Association.—The sixty-seventh annual session of the California Medical Association, held at the Hotel Huntington in Pasadena, May 9-12, has come and gone, and its events now take their place in the records of the past. The meetings began on Sunday and continued without interruption through Thursday noon. The scientific programs and exhibits, and all the social events of the occasion measured up to an excellent standard. The dinner to President Howard Morrow was made particularly enjoyable through entertainment supplied by the Alameda delegation, who brought with them several Oakland artists. The Woman's Auxiliary reported most gratifying meetings. The registration desks and commercial exhibits were housed in a specially arranged tent-like structure set up in a patio conveniently accessible. The general verdict, therefore, apparently of everyone who registered was that "a good time was had by all."

* * *

Dr. Howard Morrow Is Now the Past President, Dr. William W. Roblee Assumes the Presidency, and Dr. Charles A. Dukes Becomes President-Elect.—At this time, the appreciation of the Association is expressed to Dr. Howard Morrow of San Francisco, the retiring president, for his efficient services during the past year.

The California Medical Association also greets the incoming president, Dr. William W. Roblee of Riverside, who takes up the responsibilities laid down by his predecessors. In his many years of service, Doctor Roblee has given of himself without stint and without thought of self. Hence, he may look forward to, and will receive the generous support of every Association member.

The newly elected President-elect is Dr. Charles A. Dukes of Oakland, and it is of interest that he was a classmate of Doctor Roblee at Stanford's Cooper Medical College, both being members of the Class of '95. Confrères throughout California are familiar with the valuable work Doctor Dukes has rendered as chairman of the California Cancer Commission and the Committee on Public Relations. His continued service in this new position will add to his laurels as an efficient administrator, and as a loyal, broad-visioned disciple in the guild of physicians.

So much for the nonce concerning this year's annual session. Full reports of the meetings of the House of Delegates will appear in the July issue of CALIFORNIA AND WESTERN MEDICINE.

* * *

American Medical Association Convenes in San Francisco June 13-17.—We turn from the pleasant memories of a State Association gathering to look forward, with equal pleasure, to the

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

eighty-ninth annual session of the American Medical Association which will begin its five days of meetings in San Francisco on Monday, June 13. The *Journal of the American Medical Association*, in its issue of May 17, gives a comprehensive outline of the many activities in scientific and organized medicine which will then and there be considered. If you are not a subscriber of the *Journal A. M. A.*, it will be worth the while to borrow a copy from some colleague and orient yourself concerning the work of our national organization, in which the California Medical Association is one of the large constituent state units. And then, if you have in mind to go to San Francisco for the American Medical Association annual session, it would be wise to write the California Medical Association, Suite 2004, 450 Sutter Street, San Francisco, in regard to hotel reservations. The hotel rates were given on page 1573 of the *Journal A. M. A.* of May 7.

The many physicians who continue to attend meetings of the American Medical Association are unanimous in expressing a favorable opinion of their value. Inasmuch as the medical profession of California is this year's host, the registration of physicians from our state should be only such as to reflect the highest credit upon ourselves. In this connection, if you are not a "Fellow" of the American Medical Association, it would be well to write at once to the American Medical Association, 535 North Dearborn Street, Chicago, and make request for a fellowship application blank. As stated by Dr. Junius B. Harris, in his Salutation which appears in this number, the payment of the fellowship dues, of seven dollars, entitles each Fellow to a subscription to the *Journal A. M. A.*, while a subscription to the American Medical Association journal alone, and without the privileges of a fellowship, costs the same amount, namely, $7.

The officers of the California Medical Association urge you to attend this eighty-ninth annual session of the American Medical Association (and so utilize in excellent way some of your vacation days); and also recommend that if you are a subscriber to the *Journal A. M. A.*, but not a "Fellow," to write and secure such fellowship, in order to be able to register and take part in the meetings. If you send your application to the California Medical Association, 450 Sutter Street, San Francisco, the communication will be referred to the proper A. M. A. officers. You will deny yourself real inspiration and pleasure if you fail to attend the June 13-17 session of the A. M. A. in San Francisco.

"COUNTY INSTITUTIONS COMMISSIONS" FOR THE COUNTY HOSPITALS OF CALIFORNIA VERY MUCH NEEDED

How County Hospital Purposes Have Changed in Recent Years.—During the last ten years, in many of the publicly supported county hospitals of California, the functions of those institutions, regarding the group of citizens who are there eligible for hospitalization and medical care as well as financial and other factors having relation thereto, have undergone changes that are most important to patients, taxpayers, and the members of the medical profession. How far, for example, from almost generally accepted procedures in county hospital management some of these innovations can go, has been shown in recent issues of California and Western Medicine, in the discussion of serious problems that have arisen at the Los Angeles County General Hospital.*

* * *

Illegal and Injudicious Procedures in Vogue in Some County Hospitals of California.—It is not necessary again to go into detailed discussion of some of the matters previously commented upon, it being sufficient to mention the following:

1. That public moneys seemingly have been expended in unwise and perhaps illegal adventures and efforts intended to collect money from indigent patients, when, according to California law, hospitalization and medical care supposedly should be given without cost to such needy citizens;

2. That the fundamental purpose for which county hospitals were brought into being still exists, namely, to place the facilities in such institutions only at the service of those citizens who, as sick and injured, lack the financial resources to pay for needed hospital and medical care;

3. When hospitalization costs are calculated and a fee table for such service is established by a board of supervisors, that the rates shall be fair and equitable, and not in excess of the costs of hospitalization service of equal or better standard, purchasable in private hospitals of the same community;

4. When statements for hospitalization services are rendered to "medically indigent" citizens (persons able to provide shelter, food and clothing for themselves and their dependents, but with insufficient funds to cover hospital and medical care costs), the law as interpreted by the California courts shall be observed, namely, that such "partly" or "medically indigent" persons shall be called upon to pay only so much of their hospitalization costs as would represent a fair and equitable proportion of their financial resources;

5. That a patient admitted to a county hospital should himself be informed (or through a legal guardian) within, say, three days after admittance, as to what the average costs per day and week would probably be (applying here the same routine that exists in private hospitals); and that thereafter, weekly if possible, or semimonthly or monthly, in any event, a memorandum of the approximate costs would be rendered (again, as in private hospitals), in order that the patient, if partly indigent, could ask for discharge, in case the costs were mounting to heights impossible for the individual to pay, in whole or in part;

6. That the routine plan of having patients, seriously ill or otherwise, sign over in blank, as it

* See items on Los Angeles County Hospital in this issue, on page 477. Also previous articles in recent issues as follows: February, 1938, pp. 73 and 78; March, pp. 156 and 216; April, pp. 234 and 279; and May, pp. 309 and 383.

were, all rights to burial and other insurance policies or equities in small and heavily mortgaged properties, be replaced by a system with more of the human element and human individualization in evidence;

7. That when statements for hospitalization are sent out, the items should be so worded that the county operating the hospital may not be accused of having attempted to secure reimbursement under fraudulent pretenses; thus, when a county sends out bills for an item such as "Use of the Operating Room and Personnel," this fact should be so stated, instead of naming the operation and giving the impression that the charge was for the surgical operation (for which operation, if it had been performed by an attending surgeon who was giving gratuitous service, the county would have no legal right to make a charge);

8. That nonindigent citizens—viz., sick and injured citizens who are neither "indigent" nor "medically indigent"—should not be permitted to use the facilities of a county hospital, except in cases of great emergencies, such as earthquakes and fires; because, to admit such nonindigents is clearly an illegal act, for which the constituted authorities could be held liable in law, since they would in such instances be using public moneys for private purposes;

9. That if a collection bureau is established by a county for its hospital, its administration should not be permitted to waste public moneys in efforts to collect from indigent citizens (who are legally entitled to care without cost), or improper amounts from medically indigent persons, by hiring a large clerical and other personnel to send out statements in amounts aggregating thousands of dollars, of which, perhaps, only about 5 per cent or so ever could be collected.

* * *

Improper Procedures in County Hospital Administration Must Be Stopped.—If illegal and unbusinesslike methods, such as are enunciated above, exist in one or more county hospitals in California, and if in the interests of:

1. The principle of humanitarian care for sick and injured citizens who are indigent or near-indigent;

2. The rights of taxpayers to have public moneys expended only for public purposes; and

3. The maintenance of proper professional and business standards,

it is desirable to remedy administrative deficiencies such as have been outlined, what are the constructive plan or plans that may then be brought forward for consideration?

* * *

The Solution of These County Hospital Problems Is Found in "Institutions Commissions." It is our opinion, based upon experience on a county hospital medical board extending over a period of more than thirty continuous years (during which we have seen one political administration follow the other) that the answer is to be found in an "Institutions Commission" modeled after the excellent form brought into existence in 1917 for Alameda County.* That Commission came into being largely through the efforts of Dr. O. D. Hamlin, himself an ex-president of the California Medical Association, who persuaded an influential group of fellow citizens of Oakland to join with him in an effort to induce the Board of Supervisors of Alameda County to authorize an "Institutions Commission" which, by ordinance, was warranted to

"have jurisdiction over the County Hospital, the County Infirmary, and the Tuberculosis Hospital of the County of Alameda, of all employees thereof, and of all activities carried on therein, and of all institutions for the sick, injured or infirm, maintained and operated by the county of Alameda, not including therein the Emergency Hospital."

* * *

Alameda County Institutions Commission.—The foregoing ordinance was adopted on July 16, 1917, and the hospitals mentioned above have been under the jurisdiction of this "Alameda County Institutions Commission" since that year.

On August 23, 1932, the original ordinance was repealed by "An Ordinance Relating to the Powers and Duties of the Alameda County Institutions Commission and Repealing Ordinance No. 208 entitled, 'An Ordinance Creating the Alameda County Public Health Center Board and Prescribing Its Powers and Duties Pursuant to the Provisions of Section 13 of the Charter of the County of Alameda.'"

The Alameda County Institutions Commission, as at present constituted, is operating under the revised ordinance having the above title, adopted in 1932, and which, for the information of our readers, appears on page 475 of this issue, in the Special Articles section. The ordinance is commended for most careful perusal by every member of the California Medical Association, because in it we find a method that has already prevented, and can overcome and prevent procedures such as were indicated in the beginning of these comments.

In fact, the Institutions Commission plan of supervision of county hospitals and their associated activities is today, without doubt, the most logically indicated method of operation for these public institutions that have such wide scope and extended influence on the health and happiness of citizens with lower-bracket incomes, as well as on the interests and rights of taxpayers.

The Alameda County Institutions Commission plan is not 100 per cent perfect, but it can serve as an excellent model for other counties. Take the time to read or scan its provisions.

* * *

How Could the Alameda Institutions Commission Plan Be Applied, for Example, to the Large Los Angeles County General Hospital? At the beginning of these comments, references were given to articles on the Los Angeles County

* References to this Alameda Institutions Commission plan was made in articles by Dr. George G. Reinle in CALIFORNIA AND WESTERN MEDICINE, July 1913, page 1; and in the issue of November, 1933, pp. 340 and 289. Another reference appears in this issue, on page 475.

Hospital which have appeared in recent issues of California and Western Medicine. Therefore, it is not necessary to reiterate what has been previously stated concerning indicated changes for that institution. In one press clipping in this issue* commenting upon the requested budgets of the charitable institutions of the County of Los Angeles, the following estimates for maintenance costs for one year were given:

	Budget Estimate
Los Angeles County General Hospital	$5,595,511
Olive View Sanatorium (tuberculosis)	1,335,982

The above are financial amounts of little less than amazing proportions, made necessary to cover the maintenance costs of these large charitable institutions in one of the metropolitan centers of California.

* * *

Present Charitable Institutions Ordinance of Los Angeles County.—The statutes of California place the primary responsibility of expending these public moneys on the five members of the Board of Supervisors of Los Angeles. That Board, however, has many other responsibilities, and by Ordinance No. 2168 (New Series) Eff. 11-30-1932 it is provided that a county employee known as the "Superintendent of Charities" shall be vested with the authority to manage the aforementioned institutions, the exact language being as follows:

Rule 1. Subject to the direction of the Board of Supervisors and rules and regulations adopted by the Board, the Superintendent of Charities shall be the head of, and it shall be his duty to direct, supervise and control all activities of the Department of Charities, including the General Hospital, Rancho Los Amigos, Olive View Sanatorium, County Cemetery, and the Bureau of County Welfare. He shall enforce rules and regulations for the conduct and government of the various bureaus of the Department of Charities and of the charitable institutions of the county.

Rule 2. The Superintendent of Charities shall have power to appoint the Executive Superintendent of the General Hospital, Superintendent of Rancho Los Amigos, Superintendent of Olive View Sanatorium, Superintendent of the County Cemetery, and the Superintendent of the Bureau of County Welfare.

Rule 2a. Subject to the supervision and direction of the Superintendent of Charities the Executive Superintendent of the General Hospital shall have immediate charge and control of the General Hospital, and with the approval of the Superintendent of Charities shall have the power to appoint all employees of the General Hospital.

Comment.—In a plan for an Institutions Commission for Los Angeles County, the duties and powers now vested in the Superintendent of Charities would be vested in the Commission, the Commission taking over the Superintendent's major functions as to appointments and so on, and he in turn, perhaps, occupying a place in relation to the Institutions Commission similar to that which the Executive Superintendent of the General Hospital (see Rule 2a above) at present holds to himself.

How Should an Institutions Commission Be Composed?—A proposed plan for an institutions Commission would be somewhat as follows:

Number of Members.—Seven.

Term of Office.—Seven years each.

How Appointed.—One member to be appointed each year by the Board of Supervisors. (The terms of supervisors are four years each, in a staggering arrangement. Therefore, appointees in succeeding years would be responsive to the wishes of the electorate as expressed in their election of supervisors.)

Qualifications.—The seven members of the Institutions Commission to be citizens, who have had prior legal residence in the county for at least five years, and who have had special training or experience in administrative matters having to do with business, or with social welfare activities, or with professional work. The honorarium to be twenty dollars for each meeting, provided, that no more than three meetings in a single month would be entitled to such honorarium.

* * *

Institutions Commissions Can Be Created by Ordinances or by Charter Amendments.—In Alameda County, the Institutions Commission came into being through an ordinance, and it has done its work so well since 1917 that no effort has ever been made by succeeding Boards of Supervisors to repeal the enactments. However, another method, and one which could be used in counties operating under county charters—as in Los Angeles County, for instance—would be the submittal of a charter amendment that might create an Institutions Commission. An Institutions Commission, once so created, would continue to operate until such time as the electorate deemed it wise to provide otherwise.

* * *

Government of County Hospitals in California of Vital Importance.—This subject of Institutions Commissions, as above commented upon, will be referred to in future issues, but it is to be hoped that what has been stated here and elsewhere in this issue of the Official Journal may stimulate further thought and discussion. No public health problem in California has closer implications with medical practice in this state than the publicly supported county hospitals. These institutions can be potent factors in determining what the future shall bring to scientific and organized medicine. It is to be desired that even during the coming vacation months the subject will receive attention by the proper medical society committees in every county in California.

MEDICAL CARE OF MIGRATORY WORKERS

"Agricultural Workers' Health and Medical Association," a Corporation.—Under the caption, "California 'Migrants': 'Workers' and 'Rovers'," the problem of medical care for migratory workers in California received brief editorial

* For recent press clippings concerning Los Angeles County Hospital see page 477.

comment in California and Western Medicine in its issue of August, 1937, on page 74. Some public health factors having relation to these itinerant workers have become so serious that the Federal Government, through the Farm Security Administration, acting in coöperation with the California State Board of Public Health, recently brought into being a nonprofit corporation known as the "Agricultural Workers Health and Medical Association," the corporation taking up its work with an appropriation of $100,000, secured from the Federal Government.

A report, submitted by Dr. Karl L. Schaupp of San Francisco, one of the seven directors of the corporation, outlines the purposes and tentative plans under which it is proposed to work. Request is made for comments and criticisms, the plan having been previously discussed with representatives of twenty county medical societies of California, in whose districts the medical care of migratory workers has become an important problem. Members of the Association are urged to read the report of Doctor Schaupp, which appears on page 460. He and his associates will welcome your suggestions.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 458.

EDITORIAL COMMENT†

CRYSTALLIZED LYSOZYME

The recent crystallization of Fleming's "lysozyme" by Doctors Abraham and Robinson[1] of Oxford University is a major victory in basic immunologic research, which may well lead in time to practical clinical results. This fat-soluble bacteriophage-like substance is present in particularly high titer in the tears and nasal secretions, and is believed by the English investigators to be the major natural defenses of the conjunctiva and nasal mucosa against certain types of bacterial infection. The defensive enzyme is apparently a protein which is particularly rich in the two amino-acids, tyrosin and tryptophan.

This natural antiseptic was discovered in 1922 by Doctor Fleming[2] of St. Mary's Hospital, London, who studied in detail its action on certain nonpathogenic cocci. Wolff,[3] of the University of Amsterdam, afterward showed the lysozyme to be almost equally effective against certain pathogenic microörganisms, such as the gonococcus, Staphylococcus aureus, Staphylococcus hemolyticus, meningococci, and tubercle bacillus.

Lysozyme is apparently widely distributed in human tissues. Tears, sputum, and nasal secretions show lytic action on susceptible cocci in dilution as high as 1 : 300,000. Blood serum, normal saliva, ascitic fluid, cystic fluids, and pus are of lower lytic titers, being rarely effective in dilutions higher than 1 : 1000. Cerebrospinal fluid, urine, and sweat are practically free from the lytic enzyme, never showing titers greater than 1 : 10. Aqueous extracts of dehydrated acetone-fixed tissues show cartilage and the gastric mucosa to contain the lytic enzyme in particularly high concentrations, with intermediary concentrations in the liver, tonsils, intestines, and meninges. Kidney and skin give particularly low yields. Traces of the lytic enzyme are demonstrable in many vegetables, *e. g.*, turnips.

Unlike the water-soluble Twort bacteriophage the Fleming fat-soluble, "lysozyme," is equally active against dead bacteria. At 37 degrees centigrade an opaque suspension of living or dead Micrococcus lysodeikticus, for example, is almost completely cleared in a few seconds. The Twort bacteriophage requires several hours to effect an equal degree of lysis.

Like the bacteriophage, however, the amount of lysozyme in a bacterial suspension increases as a result of lysis, the increase being roughly proportional with the number of bacteria dissolved. Serial transmission of the lysozyme, however, has not yet been accomplished.

Lysozyme-resisted strains of susceptible cocci are readily produced by growing the cocci in the presence of sublytic concentrations of the enzyme. Cocci which have an acquired resistance to the lysozyme in human tears are equally resistant to lysozymes from other animal or vegetable tissues. This suggests that all lysozymes thus far studied are of the same immunochemical specificity.

Lysozyme is a remarkably stable enzyme. It may be stored without appreciable deterioration for many months, with or without the addition of chemical preservatives. It can be precipitated by alcohol or acetone without loss of titer, can be desiccated and redissolved in aqueous solution without depreciation. Unlike the Twort bacteriophage, the Fleming lysozyme is not inhibited by defibrinated blood.

The fact that lysozyme has no demonstrable bactericidal effects in S. viridans, pneumococcus, diphtheria bacilli or colon bacilli, detracts but little from its practical clinical interest. Its alleged high titer against the gonococcus would in itself justify its detailed study.

The Oxford biochemists found that lysozyme may be crystallized from n/20 acetic acid extracts by concentrating the extracts in a vacuum desiccator. The initial products thus obtained are dodecahedral crystals. Purification by repeated crystallization has not yet been reported. Injected intravenously into laboratory animals, lysozyme disappears rapidly from the circulation. Wolff[3]

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Abraham, E. P., and Robinson, R.: Nature, 140:24 (Aug. 3), 1937.

2 Fleming, A.: Proc. Roy. Soc. B., 93:306, 1922. Fleming, A., and Allison, V. D.: Brit. J. Exp. Path., 3:252, 1922.

3 Wolff, L. K.: Zeitschr. f. Immunitätsforsch., 50:88, 1927; 54:188, 1927–1928.

believes that this disappearance is due to its lipoid solubility. This belief is based on the fact that in the test-tube lysozyme is absorbed quantitatively by anhydrous lecithin and cannot be recovered from the lecithin by repeated washings with salt solution. If the anhydrous lecithin-lysozyme complex is dissolved by absolute methyl alcohol, however, the lysozyme can be recovered quantitatively from the undissolved salt residue.

Whether or not lysozyme is synthesized in the animal body, or, like certain vitamins, is a nutritional factor conserved by the animal tissues, has not yet been determined. Egg white, for example, contains about 0.01 milligram lysozyme per cubic centimeter. Egg yolk contains many hundred times this concentration. Many vegetables are also natural sources of this protein antiseptic.

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Stanford University.

POSTOPERATIVE TREATMENT IN PERITONITIS

This discussion is intended to apply to generalized peritonitis and not to localized intraperitoneal abscesses. After the most gentle and, usually, the most conservative operative intervention designed to remove or stop the source of contamination of the peritoneal cavity has been carried out, the surgeon is confronted with the equally important postoperative care. Much has been learned in recent years in clinical practice and the many advances which have been made in biochemistry, physiology and metabolism are applicable to this problem. In peritonitis the absorption from multiple partial obstruction due to intestinal distention is a greater lethal factor than the infection directly. It logically follows that the prevention of distention is of great importance. The campaign to this end must be started immediately after the operation.

The first step in this fight is to place a nasal duodenal tube into the stomach and connect it with a Connell suction. This should be done immediately after operation, and continued until the patient is passing gas per rectum freely without colon flushes or enemata. The importance of constant lavage of the stomach and draining off the regurgitated upper intestinal contents is urgent. In this connection it is to be remembered that over 70 per cent of the gas causing distention of the gastro-intestinal tract is swallowed air as a result of attempts on the part of the patient to belch. The tube in the stomach, with constant suction, eliminates this big factor and the collapsed stomach allows more room within the abdomen for the coils of distended gut, decreasing the degree of obstruction at points of angulation of the different loops. The upper loops can empty into the stomach making further room for the lower loops to empty upward.

The intestines are vitally involved in the inflammatory process, and the principle of providing rest for such sick or injured tissue should be strictly followed. Hot compresses to the abdomen, when properly applied and not allowed to get cold, make for comfort and probably have some beneficial effect in keeping up the muscle tone of the intestines without artificially stimulating peristalsis. Morphin given in adequate doses for comfort, but not to excess, has been shown experimentally to aid in the maintaining of normal muscle tone of the intestines. The use of eserin, pituitrin, petressin, concentrated saline, etc., to whip up the sick, distended intestines is most definitely injurious. One may secure the expulsion of gas by these drastic drugs in conjunction with flushes and enemata, but more often than not, a few hours later, the patient is more distended than ever. The pernicious practice of routine colon flushes, rectal drips and early enemas are contra-indicated. A low colon flush or small enema is of assistance only after natural peristalsis has been definitely reëstablished, but not before. A rectal tube may be inserted twice or three times daily after the first twenty-four hours, and this should be the limit of meddling with the gastro-intestinal tract until peristalsis is active. Early high colon flushes or high enemata are practically as harmful in peritonitis as early feeding by mouth, which is agreed to be detrimental. Rectal instillations cause reverse peristalsis and stirs up the pus.

In brief, the surgeon should use all agencies at his command to put the gastro-intestinal tract completely at rest until nature is ready for assistance. When the patient is ready for help a low enema of three hundred cubic centimeters is preferable to the so-called high enemata. The desire to defecate is caused by a sudden distention of the rectum and the painful contractions due to over-distention of the bowel higher up serves no useful purpose and in peritonitis does harm.

Having outlined the campaign for rest of the sick guts, the next essential is to supply fluid, salt and nourishment in the proper quantity. A sick patient with peritonitis loses from 1,500 to 2,500 cubic centimeters of fluid in each twenty-four hours by evaporation from the skin and in the expired air. This evaporation has first call on the available fluids possessed by the patient's tissues. For sick patients to adequately free the body of nitrogenous waste products, there must be excreted at least one thousand cubic centimeters of urine daily.

Thus three thousand to 3,500 cubic centimeters of fluid is required in each twenty-four hours. Patients who have peritonitis most often are emergency cases and are often dehydrated. Coller[1] and his collaborators have shown that to overcome such dehydration 3,500 cubic centimeters of fluid is required to be able to start from scratch. This seven thousand cubic centimeters of required fluid is a startling amount for the first twenty-four hours, and in most instances would be dangerous. Each case must be individualized, and it is not necessary to give all of the seven thousand cubic centimeters in the first twenty-four hours. Yet more often than not, the patient does not get enough fluid which should be given in an adequate quantity but at a slow rate of speed.

From clinical experience and physiological facts, we know the above to be the required volume of

1 Coller, Fred A.: Water Balance in Surgery, J. A. M. A., Vol. 108, No. 1 (Jan. 2), 1937.

fluid, but the kind of fluid, the amount and kind of salt, and the amount of sugar are of equal importance. Since the stomach is being constantly emptied, there is a complete loss of the chlorides secreted as hydrochloric acid in the gastric juice. These chlorides must be replaced. This can be done in the form of normal saline or Ringer's Solution. However, the patient must not receive too much sodium or his kidneys may cease to function, and he will develop edema, suppression of urine and uremia and die, not as the result of the pus in the peritoneal cavity nor to the toxic absorption from loops of obstructed gut, but a chemical death as a result of his treatment. Six to eight grams of sodium chlorid is the requirement of the average individual in normal health in each twenty-four hours. One thousand cubic centimeters of saline or Ringer's Solution will supply nine grams, which is adequate for twenty-four hours. Ringer's Solution, because of the calcium and potassium it contains, is preferable to sodium chlorid solution. If edema develops because of too much sodium, and kidneys of different people vary in their ability to cope with an excess of this element, it can be corrected by the addition of five cubic centimeters 10 per cent calcium chlorid to one of the glucose intravenous injections.

The calcium chlorid corrects the beginning alkalosis and has a remarkable effect by increasing the volume of urine and reducing the edema. The writer has used calcium chlorid in this manner for fifteen years and with gratifying results.

To prevent the development of acidosis, a sufficient amount of carbohydrates must be supplied in a usable form to furnish glycogen for the liver, and to burn completely the products of katabolism of fats. This again varies, but 5 per cent or 10 per cent glucose solution may be used alternately as indicated to supply the demand.

The facts indicate the use of the following arbitrary routine. Give one thousand cubic centimeters 10 per cent glucose in distilled water at 8 a. m., one thousand cubic centimeters Ringer's Solution intramuscularly at 1 p. m.; one thousand cubic centimeters 5 per cent glucose in distilled water at 7 p. m., and allow the patient to rest until morning. If the patient's veins are good, all fluids may be given by the intravenous routine for the benefit of comfort. Each intravenous injection of one thousand cubic centimeters should require, at least, one and one-half hours to administer to prevent the occasional occurrence of pulmonary edema from this volume of fluid if given too rapidly. In the more desperate cases and those with poor veins, continuous intravenous administration of glucose by the drop method is a more satisfactory way of furnishing the required fluids. The rate of flow should be about forty drops per minute.

This régime for from four to seven days will carry the average patient with generalized peritonitis to the point where he can again take fluids and nourishment by mouth. However, in some of the more severe cases, this procedure may have to be carried out for two to three weeks. After ten days to two weeks, the patient may develop edema due to low blood serum protein. In medical centers where laboratory facilities are available, this fall in serum protein can be detected early by blood chemistry examinations which serve as an accurate guide for proper treatment. However, not all hospitals are equipped to furnish such adequate and reliable reports and, indeed, such reports are not obligatory. The only available method of furnishing the patient who cannot eat, the required serum protein is by giving blood transfusions. Therefore, in the absence of blood chemistry examinations as a guide, a transfusion of whole blood should be given as soon as the dependent edema and a decrease in the urinary output occurs and should be repeated as often as is necessary to control edema until the patient is able to take protein by mouth.

This régime has been arrived at after trial over a period of years of water by mouth, early feeding, rectal drips, rectal instillations, colon flushes, various enemata, pituitrin, eserin, etc., and is, productive of the best results.

2000 Van Ness Avenue.

LeRoy Brooks,
San Francisco.

GLAUCOMA

With increase in longevity, a corresponding increase in the number of patients with simple glaucoma is to be expected. The importance of glaucoma in the practice of ophthalmology can be seen from the fact that, of the nineteen papers presented before the Section on Ophthalmology of the American Medical Association in 1936, three dealt with this subject.[1]

Glaucoma has been known from antiquity. Four centuries before Christ, Hippocrates mentioned the "glaucoses" as the known affections of advancing age. Of course, the knowledge he possessed was hazy, as he did not distinguish cataracts from eye conditions caused by increased intra-ocular pressure. The Greek and Latin writers who followed him learned one important fact, that there was a difference between the various eye conditions which took place behind the pupil and caused blindness. There were the "suffusions" which were favorable from the operative point of view, and the glaucomata which were unfavorable. Of course, it was the congestive variety that has been thus known, since the noncongestive (simple) variety can be diagnosed primarily by the ophthalmoscope. The name "glaucoma" is from the Greek word γλαύκωμα, derived from γλαυκός, meaning "sea-green or gray," and this condition was so called on account of the greenish reflex from the pupils in glaucoma.

Congestive glaucoma was usually regarded as having some connection with gout, and was called ophthalmia atritica. The noncongestive type was considered as produced by diseases of the deep structures of the eye, and with other kinds of blindness was known under the common name of

1 Weeks, W. W.: Ocular Hypertension in Glaucoma—Errors in Operative Technique Likely to Cause Failures in Operations for Its Control. Wheeler, J. M.: Iridectomy with Cyclodialysis for the Reduction of Ocular Tension. Barkan, O.: A New Operation for Chronic Glaucoma, Tr. Sect. Ophth., A. M. A., 1936.

"amaurosis." As late as 1844, in a popular textbook on diseases of the eye by Jeaffreson, the cause of glaucoma was given as due to a disease of the vitreous body.

Sir William McKenzie, in 1830, was the first to recognize increased intra-ocular tension as the essential part of glaucoma, whose work was later emphasized by von Graefe. McKenzie recommended repeated parancentesis for glaucoma.

The invention of the ophthalmoscope was the beginning of the golden age in our knowledge and clarification of various eye conditions. Although ophthalmology is the oldest medical specialty, ophthalmology as we know it today is one of the youngest, for its birth was the discovery of the ophthalmoscope by Helmholtz in 1851.

Soon after the discovery of the ophthalmoscope, Adolph Weber made the clinical observation of the cupping of the optic disc. This was quickly confirmed by Heinrich Müller's studies of the pathological anatomy of the eye. Five years later, in 1856, von Graefe introduced his iridectomy for the first time in glaucoma. It is interesting to note that von Graefe's first paper on iridectomy presented a means of treatment of chronic iritis and iridochoroiditis. It was a year later when his paper on iridectomy in glaucoma appeared.

In 1862 Sir William Bowman introduced the method of gradual digital tonometry, together with the use of the three familiar degrees, above and below the normal, respectively. Schiotz introduced his famous tonometer in 1910, and McLean his in 1919.

We owe a great deal to von Graefe's disciple, de Wecker, who fought the rising tide of opposition, which at one time threatened prematurely to engulf his master's valuable method. De Wecker has a higher claim still on our admiration for recognizing the value of a filtering scar, and the fact that he introduced Stellwag's sclerotomy.

Leber's classic work established the secretion of the intra-ocular fluid by the ciliary body, and the method of excretion of that fluid. This paved the way for Max Knies and Adolph Weber who, working independently and following the clue given by Leber, simultaneously discovered the important fact of the closure of the angle of the anterior chamber by adhesion of the iris to the cornea in cases of glaucoma.

In 1863 Argyll Robertson, of Argyll Robertson pupil fame, wrote a paper on the calabar bean, eserin, as a new agent in ophthalmic practice. Argyll Robertson did not recognize its value as a myotic. It was in 1876 that Laqueue of Strassburg introduced myotics in the treatment of glaucoma, and he, too, had to maintain his stand courageously in the teeth of opposition which it started. He was fortunate to have as a supporter the veteran Snellen.

Among pioneers in the introduction of the study of the visual fields, we owe a great deal to the three musketeers: Haffmans, a pupil of Donders, who in 1860 studied visual fields; Bjerrum, who did his studies between 1889 and 1892, and his pupil, Rönne.

Heine described his cyclodialysis in 1905, and a year later Lagrange introduced his operation of sclerotomy. Elliott followed with his trephine operation in 1909.

Although tremendous advances have been made in the treatment of glaucoma since von Graefe introduced his iridectomy, a satisfactory treatment of glaucoma still remains to be found.

490 Post Street.

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Defective eyesight is an important contributing cause of many automobile accidents, it is pointed out by Alvhh R. Lauer, Ph.D., in a report on "Motor Vision in Safe Driving," published by the National Society for the Prevention of Blindness. Doctor Lauer is associate professor of psychology in the Iowa State College, Ames, Iowa.

Many highway accidents occur, he says, because of the following reasons:

1. Failure of the driver to see or interpret a warning signal in time to avoid danger.
2. Failure of the driver to determine the exact location of a vehicle, person, or other object in time to avoid collision.
3. Failure of the driver to see objects or persons at night.

"The first classification of failures of the driver," says Doctor Lauer, "may be due to lowered acuity or keenness of vision; restricted field of vision, namely, narrowed down from the sides; scotomata, or 'holes in vision,' in which part of the field objects will not be discerned; ocular dominance, or the tendency to use one eye more than the other; and lowered attention, which may result in temporary psychic blindness of one or both eyes.

"The second classification of weaknesses—that of localizing the object—may be due to poor distance judgment or muscle imbalance, causing diplopia or double images. Cases of double images with as slight as three degrees of exophoria—eyes tending to turn out—have been noted. The driver would see two pairs of headlights in the distance and think one car was attempting to pass another. In reality there was but one car.

"The third classification is that of blinding lights. Persons differ enormously in this respect. Older persons are usually more disturbed and more easily blinded by glaring lights than younger persons. Likewise lowered acuity is associated with inability to tolerate strong lights. Persons least disturbed by glare can stand forty times as much contrast as those most affected. We are hoping that the perfection of polarizing glass may solve the glare problem soon.

"One of the best ways to decrease accidents is to apprise the driver of his actual potentiality as a driver. This has been demonstrated in commercial companies. Most drivers think they are good. Actually, some are 15-mile-an-hour drivers. Others are 25-mile-an-hour drivers. Still others may drive safely at 35, 45, or 55 miles an hour, under favorable conditions. A very few might drive safely at 65 miles an hour. Our experience with racing drivers shows that they drive only 45 to 50 miles an hour when on the highway, yet some 25-mile-an-hour drivers have boasted to me that they do 90 miles an hour.

"A driver should go no faster than his visibility allows. If his eyes are defective, they should be made as good as possible. There will be plenty of danger from other causes at best."—*National Society for the Prevention of Blindness, Inc.*

No enterprise in the wide range of human experience can rank with training the mind. If, therefore, we have received from heaven nothing so good as the mind, what should be more worthy of exercise and cultivation? No other adventure is to be compared with it. Through it civilization and all man's higher achievements have been won. The report of a gun does not carry so far as the music of the lyre. To pursue intellectual ideals, unlike galloping with a king in a game park, is a glorious experience open to every man who cares to live richly and well.

ORIGINAL ARTICLES

PHYSICIANS' ACTIVITIES IN THE FIELD OF MEDICINE*

By Howard Morrow, M.D.
San Francisco

ONE outstanding achievement of the twentieth century, as far as medicine is concerned, is the change in attitude toward venereal diseases on the part of the laity and the medical profession. The campaign to stamp out these diseases was instituted only two years ago by Federal and State authorities, and has made great advances in this field. The subject of venereal disease has been brought out into the light, imparting to millions of people the real significance of these infections. The cloak of secrecy and moral stigma which has surrounded this problem from time immemorial prevented the dissemination of true knowledge to the public. It is now granted by all that venereal disease exists: that it can be prevented, and that, by proper treatment, it can be eradicated.

Much credit must be given to Surgeon-General Parran, who fostered the program of venereal disease control. He, with the United States Public Health Service, and the health agencies of the various states, in coöperation with the teachers in medical schools, have acted jointly to acquaint the medical profession and the laity with the most modern methods of the treatment of these diseases.

INCREASING KNOWLEDGE CONCERNING SYPHILIS

Before outlining the program for venereal disease control now being undertaken in California, I should like to recall briefly the tremendous changes in our knowledge of syphilis which have taken place since the late nineties, when I was a medical student. It is true that much was known of this disease from a clinical standpoint, but much confusion existed so far as many truly syphilitic manifestations were concerned. Paresis, for instance, was thought to be syphilitic; but not until the discovery of the Treponema pallidum, years later, were we certain that it was syphilitic. Treatment had not advanced for hundreds of years and we still had only mercury and iodides to combat the disease.

The modern era of syphilis began in 1905 when Schaudinn and Hoffman discovered the Treponema pallidum, and announced it as the cause of syphilis. The Wassermann test for the serologic diagnosis of syphilis followed in 1906. Then Ehrlich synthesized salvarsan in 1910. In the space of five years the etiology of syphilis had been solved, an invaluable diagnostic test had been introduced, and a specific therapeutic agent had been discovered. With this impetus great strides were made in the diagnosis and treatment of the disease.

As a result of these discoveries, a third-year medical student can demonstrate the Treponema pallidum in the secretions of the primary or secondary lesions; whereas, when I was a student we had to wait until secondary symptoms appeared before an accurate diagnosis could be made.

The next five to ten years brought out many facts concerning the proper treatment of the disease. It was soon learned that even with a potent spirocheticide, such as salvarsan, a cure could not be effected quickly, and that it required repeated attacks upon the organisms, over a period of one to three years, before cure could be obtained.

Other great discoveries in the field of syphilis followed: the dark field microscope was invented; and the necessity and value of lumbar puncture were pointed out.

In 1917, Von Juarreg announced that patients insane with general paresis frequently were restored to health and sanity by innoculating them with malarial parasites. The field of fever therapy has been greatly extended, and today we administer artificial fever by means of simple appliances.

Another great advance in the treatment of neurosyphilis was the introduction of tryparsamide in 1917 by Heidelberger of the Rockefeller Foundation. This drug with fever therapy has given a real hope of relief to thousands of unfortunate neurosyphilitics. As a result, our institutions for the insane are no longer filled with bedridden paralytic syphilitics.

Then in 1920, Levaditi introduced bismuth into syphilotherapy. This drug has replaced mercury to a large extent. Bismuth is a much more active spirocheticide, and much less toxic than mercury. It causes little pain when injected. The introduction of bismuth has made anti-syphilitic therapy much more humane than in the days of mercurial stomatitis, nephritis, painful buttocks, and similar therapeutic sequelae.

PROGNOSIS AND EARLY DIAGNOSES

With these discoveries, the prognosis in the treated syphilitic has been entirely changed from the time of my early medical days. Then few syphilitics were cured. Today the patient who starts treatment during the first few days of his infection has a 90 to 95 per cent chance of cure, and somewhat less so if he waits for a few weeks before consulting his physician. If every syphilitic could be treated in the early phase of the disease, or even in the early latent period, the late catastrophies of the disease, such as paresis, tabes, aortitis aneurysm, etc., would become a rarity. Even in the late stages of the disease, much relief is obtained by proper treatment.

PLACE OF SYPHILIS IN PUBLIC HEALTH PROGRAMS

However, it is obvious that it is our duty and aim to diagnose syphilis as early as possible and see that the proper treatment is instituted. That, in a word, is the purpose of our public health program, as it relates to venereal disease.

SUMMARY OF ONE YEAR'S ACTIVITIES IN VENEREAL DISEASE CONTROL

The Bureau of Venereal Diseases was established within the State Department of Public Health February 1, 1937, using funds allocated to the State of California by the United States Public Health Service.

*Address of President Howard Morrow. Read at the first general meeting of the sixty-seventh annual session of the California Medical Association, Hotel Huntington, Pasadena, May 9 to 12, 1938.

The movement was markedly stimulated by the adoption of special legislation and appropriation of State funds at the 1937 session of the State Legislature. This law, known as Chapter 787, Statutes of 1937, became effective August 27, 1937.

In the fifteen months since the formation of the Bureau, the control program has gradually taken form. The present activities and plans may be discussed under five headings:

First. — Information accumulated concerning the extent and nature of the problem.

Second.—Improvement of diagnostic and treatment facilities in public clinics.

Third.—Improvement of the administration of the program by local health departments.

Fourth.—Improvement in the coöperation and efficiency of physicians in private practice.

Fifth.—Informative programs for the general public.

These may now be considered in more detail.

I.—*Information concerning the extent and nature of the venereal disease problem:*

Preliminary one-day surveys in Fresno, Madera, Stanislaus, and Orange counties have indicated that there are approximately six cases per one thousand of population constantly under treatment for venereal disease in California. This represents a case load of about 40,000 patients for the entire State. Approximately 25 per cent of these patients are being treated in public clinics, 75 per cent by about 5,000 private physicians.

An unknown number of patients, perhaps an equal number, who should be receiving treatment are not under any medical care. We estimate that free clinic facilities are needed for approximately two or three patients per 1,000 of population. In a county of 100,000 population free medical care will need to be provided for from 200 to 300 patients. This number may reach four or five cases per 1,000 in the more urban centers.

Information has been accumulated as to the amount of money being expended upon control activities, and as to the cost of the diseases to the State. Even with additional funds now available, only 5 cents per capita per year is available for control measures, yet 10 cents per capita per year is being expended for the one item of care of our syphilitic insane in our State hospitals.

Statistics are being compiled on reporting, on clinic activities, on publicity methods, etc., all designed to guide us in the further development of the program. Further surveys of incidence and prevalence are being planned.

We are accumulating information with reference to the rôle of prostitution in the transmission of these diseases. A survey of most of the rural districts of the State has already been completed.

Wassermann surveys are being conducted, notably among S. R. A. applicants. Approximately 10 per cent of applicants to the S. R. A. camps at Stockton and at Pacoima have been found to have positive blood Wassermanns.

II.—*Diagnostic and treatment facilities:*

Practically all of the seventy-five clinics throughout the State are now offering free diagnostic services. Adequate treatment is fundamental in the control of venereal diseases. From one-fourth to one-third of all venereal disease patients are being cared for on a no-fee basis. Patients are being referred to private physicians for treatment whenever this is possible.

Reorganization and extension of clinic facilities are under way. Direct aid in the form of personnel, clinic record forms, drugs and consultative service is being offered to established clinics that agree to adopt the standards proposed by the State Department of Public Health. Clinics are required to admit any patient for initial diagnosis and emergency treatment, any patient referred by a private physician for consultation or special tests—such patients to be returned with examination reports to the physicians referring them, and any patient unable to pay a private physician for treatment, regardless of residency. Clinics must meet certain minimum standards of record keeping, laboratory facilities, equipment, personnel; must provide modern treatment, carry on epidemiological work or coöperate with the health department doing this work in the clinic; and carry on educational activities within the clinic.

A specific example of how this works may be given. Last October a medical officer from the Bureau was assigned to a clinic being operated by the Sacramento City Health Department. In the succeeding three months the clinic was remodeled, admission fees abolished, the entrance requirements noted above adopted, record keeping improved, and the general standard of medical care improved. The attendance at the clinic has increased by more than three times (624 visits in February, 1937, as compared with 2,020 visits in February, 1938), yet no patients have come from private physicians except as directly referred to the clinics. The same plan was recently adopted by the Fresno County Hospital Clinic. Attendance at this clinic has doubled in two months. The clinic at San Bernardino is being transferred from the County Hospital to the Health Department, and will be opened on the new basis in the near future. Almost all the seventy-five clinics now operating throughout the State have indicated a desire to coöperate. Some further clinics are being established; two clinics are now being operated at the S. R. A. camps in Stockton and at Camp Waybur. There are approximately 350 men in these camps under treatment. Of 3,600 men examined at Camp Stockton thus far, 380 positive Wassermanns were found—a prevalence of 10.6 per cent.

It is hoped that eventually a chain of clinics will be available so that the vast migratory labor population can be adequately controlled. The treatment of venereal diseases is being included as part of the medical care being provided for the migratory workers.

A comparison of clinic activities during the past twenty years is of interest. Detailed reports of the twenty-four hospitals and clinics coöperating in 1917–1918 are not available. However, records for 1919–1920 indicate that at that time there were sixteen clinics reporting activities; and using the figures for that fiscal year, July, 1919 to June,

1920, we have the following comparison for syphilis patients:

Year	*1919–20*	*1927*	*1937*
Number of clinics	16	14	75
Number of new cases of syphilis	2,870	3,538	9,099
Number of treatments for syphilis	13,865	119,557	299,084

A comparison of clinic activities for 1936 and 1937 is shown in the following table:

Year	*1936*	*1937*
Number of clinics reporting	52	75
New cases { Syphilis	6,064	9,099
{ Gonorrhea	5,172	6,365
Number of treatments { Syphilis	206,185	299,084
{ Gonorrhea	70,805	143,344
Total clinic visits	290,435	484,130

A comparison of cases of syphilis and gonorrhea reported, 1933 to 1937 inclusive, and the first three months of 1938, is as follows:

	Syphilis	*Gonorrhea*
1933	10,737	7,817
1934	11,820	10,459
1935	11,957	11,634
1936	11,725	12,118
1937	17,288	17,051
Three months of 1938	5,752	4,061
	69,279	63,140

III.—*Improvement of administration in local health departments:*

Personnel is being provided, chiefly public health nurses, laboratory equipment and supplies, drugs, pamphlets, and consultative service. The most notable contribution will be in the increased epidemiological work made possible by the added personnel. This activity is already functioning in several health departments. Ten public health nurses have thus far been assigned to local health departments. The Fresno City Health Department has been converted from part-time to full-time, a laboratory provided, and diagnostic clinics set up. Laboratory equipment, particularly microscopic and darkfield, has been provided for a number of local health departments.

IV.—*Assistance to private physicians:*

1. An attempt is being made to keep physicians informed as to what is going on. An addressograph list has been prepared in our central bureau office containing the names of all medical practitioners in the State. Periodically, the 12,000 practitioners are being circularized in outlining the objectives of the program and their part in attaining these objectives. Reporting almost doubled after the first letter was sent out, in which the new reporting system was announced. A bulletin outlining the modern treatment of syphilis was enclosed in the first letter. A companion bulletin on the treatment of gonorrhea is being prepared. Pamphlets for distribution to their patients are also being provided. Three circular letters have thus far been mailed to all physicians.

2. In an effort to develop one more point of contact with the physician, a special epidemiological card has been prepared. Upon receipt of each case report from a physician in private practice, the local health department forwards to the physician this card, together with such pamphlets as are indicated for transmission to the patient. This serves automatically to keep the physician supplied with pamphlets.

Upon these cards the physician reports lapses from treatment, sources and contacts.

3. As an additional service to physicians, free public health nursing is being provided to assist them in the epidemiological work. Nurses are being assigned to local health departments for this work. This service is already functioning smoothly in some districts.

4. In order to assist physicians in the care of marginal cases, free drugs are being provided by the State.

5. Plans are going forward to provide for the payment of physicians for the care of indigent patients in rural districts where there are no available clinics.

6. Educational programs for physicians are being developed. A series of conferences for county medical society groups will be carried on during June of this year.

7. Special training courses are being offered to young physicians, consisting of a three months' medical school course, plus nine months of field work in venereal disease clinics. Ten or more young clinicians will receive this training during the fiscal year 1938-1939.

V.—*Informative program for the general public:*

A number of industrial concerns have been contacted and provided with lecturers, motion pictures, pamphlets, and posters. Active participation of lay organizations, such as the American Social Hygiene Association, junior chambers of commerce, Federated Women's Clubs, etc., has been encouraged. We have released to the newspapers a series of articles pertaining to syphilis. We are planning radio broadcasts, and the issuing of posters. A series of seven pamphlets has been issued and thus far over one-half million pamphlets distributed. We are trying to tell the public the story in a straightforward, scientific manner. An active local educational program has been developed in Los Angeles County in coöperation with the Los Angeles Junior Chamber of Commerce. Other such projects are being planned throughout the state.

The personnel of the Bureau of Venereal Diseases has been gradually expanding, being on April 15, 1938, as follows:

Chief of the Bureau, Malcolm H. Merrill, M. D.

Medical officers, Donald G. Davy, M. D., Kenneth L. Stout, M. D., and John C. Dement, M. D.

Venereal disease trainees, James Moreland, M. D., and Edward Hirschberg, M. D.

Public Health nurses, 10; stenographers, 3; laboratory technicians, 5; laboratory helpers, 3; mailing clerk, 1.

Further additions in physician and nursing personnel will be necessary. In addition, a limited number of investigators will be added to the staff.

Throughout the year temporary personnel in the way of stenographers, investigators, publicity director and mailing clerks has been used. A WPA project, allowing for ten additional clerks, stenographers and laboratory helpers, has been granted to facilitate research work for the year 1938.

To summarize, the outline of activities in venereal disease control as just given indicates that real progress in overcoming these diseases is being made.

"REPORT ON FACTUAL DATA" OF THE CALIFORNIA MEDICAL ECONOMIC SURVEY

In my next topic, I shall comment briefly upon an enterprise to which, since the year 1934, much thought was given by members of the House of Delegates in three annual and one special session, namely, the California Medical Economic Survey, which came to a conclusion in November, 1937, when the "Report on Factual Data" was brought off the press, and copies sent to the members of the Association.

Because the Association expended almost fifty thousand dollars on that project, it is proper that it should be briefly discussed.

The California Medical Association, through action on May 3, 1934, by its House of Delegates at the annual session held in Riverside, committed itself to a survey of matters having relationship to the securing of factual data concerning the power of the people of California to purchase professional medical services, and particularly to pay the costs necessarily incident to illness.

The expressed purpose was to permit this Association to assist in meeting *current* inadequacies, should any be found to exist.

A Committee of Five was authorized and appointed, which in turn secured the services of a faculty member on the economics staff of the University of California at Los Angeles, Paul A. Dodd, Ph.D., to supervise the collection and compilation of data. Subsequently, the Committee of Five was informed it would be possible to secure federal funds to supplement money advanced by this Association and help pay the wages of field representatives (citizens who, in the depression years 1934-1935, were in need of employment) to distribute and collect questionnaire blanks to citizens, provided that a constituted state agency would make request for such allocation of moneys, be responsible for proper expenditures thereof, and assume responsibility for interpretations and conclusions contained in such survey. The California Medical Association's Committee of Five petitioned the California State Board of Public Health to request the Federal Government to make such allocation through its authority; and the State Board being interested in all data having to do with the incidence and prevention of disease, as well as the early restoration to useful citizenship of all persons incapacitated through illness and injury, approved this committee's request. It expressed its willingness to act as official sponsor of such survey for the purposes enumerated in the Association's resolution, and petitioned the proper department of the United States Government, the FERA (Federal Emergency Relief Administration), to be so designated, when such sponsorship was approved and federal moneys were made available.

The foreword of the Report on Factual Data of the California Medical Economic Survey, on pages III to XLVI of that volume which was printed at the expense of the California Medical Association, gives detailed information concerning subsequent steps. The final report of Professor Dodd, on the subject matter of the Survey, was submitted by him on January 29, 1937, with a transmittal letter containing the statement, "This material is complete within itself, and is prepared for the printer." However, owing to conditions subsequently submitted by this employee, as well as the elimination of irrelevant matters contained in this report, necessitating further delays, it was not possible to bring the report to the printed page until October, 1937.

After its printing, a copy of the "Report on Factual Data" of the California Medical Economic Survey was sent to every member of the California Medical Association, and additional copies given to the federal authorities and other parties. Six thousand copies were distributed in this manner without cost to the recipients, and additional copies were placed on sale at the price of $2.00 per copy. The California Medical Association thereby fulfilled its obligation as supporting sponsor, to give publicity to the relevant data collected and compiled.

Discretion as to what should be contained in the California Medical Economic Survey was at all times vested in the State Board of Public Health, according to an official opinion of the Attorney-General of this state, who ruled that, notwithstanding nonpublic contributions, the complete report was the property of the State of California.

That this view was correct and the project recognized as successfully terminated, was evidenced by a letter in which the federal regional director quoted the Washington authorities as looking upon the California Survey as a "completed project," in the following language:

> This reply, we believe, will officially close the correspondence on this FERA [Federal Emergency Relief Act] undertaking in so far as the WPA [Federal Works Progress Administration] is concerned.

One other reference may be alluded to, namely that which in the *Journal of the American Medical Association* of February 26, 1938, on page 117B, gave the comments of the American Medical Association Bureau of Medical Economics on tables and other data compiled by the Director of the Survey, in which attention was called to the "adequacy" of the tables, and the "inadequacy" of the statistical information contained therein.

Immediately prior to and following the publications of the report, some persons composing the so-called editorial staff of the survey made public and private representations that certain irrelevant and redundant matters eliminated from the approved report should have been included therein.

What personal or private influences motivated such representations I am not in a position to state.

Lest there be any misunderstanding concerning the statements contained in the report as submitted and before necessary editing, I feel it only fair to state that it is my understanding that the report, as submitted, did not represent the views of the noted educators who composed the advisory council of the Survey. Indeed, I have information

that the so-called completed report was never submitted to all the persons comprising such council.

It is to be hoped that this unpleasant experience will lead future Houses of Delegates of the California Medical Association to consider carefully not only the attainable end-results in any projected survey, but also the total amount of money necessary to carry through the same. Having spent almost fifty thousand dollars of its reserve funds as its share of the costs of the California Medical Economic Survey, our members may well ask themselves what important facts were garnered by the group of professors in charge to warrant the expenditure of such a large sum of money.

HOSPITALIZATION INSURANCE

During recent years there has been an intense interest in the provision of hospital and medical insurance for the underprivileged, and individual members and various groups within the Society have taken active part in discussions pertaining to the subject.

Hospital insurance is of comparatively recent origin in the United States. The first association to provide nonprofit hospital insurance in California was organized in Sacramento. Upon the enactment of the Hospital Insurance Act of 1935, similar service was organized in the East Bay, later extending over a large part of the San Francisco Bay area. Following the enactment of the 1937 Nonprofit Hospital Act, fifteen hospitals of Southern California organized the Associated Hospital Service of Southern California. Recently, employees of San Francisco City and County have organized themselves into an association that provides them with hospital and medical service whenever they may be taken ill. The payment of monthly dues enables them to secure the services of, and gives them the right to select, their own physician, who is paid according to a definite fee schedule. The experiment is being watched with keen interest. All of these organizations are flourishing, and a steady gain in membership is reported.

Most of these organizations provide members with twenty-one days of hospital service, including general nursing in a ward, use of operating room, x-ray equipment, ordinary drugs and dressings. All of them, with the exception of the San Francisco City and County Association, provide only hospital service, the provision of medical service being apart and distinct from the organization itself.

MEDICAL CARE OF MIGRATORY WORKERS

Within the past few months, the Farm Security Administration has launched a comprehensive plan for the care of the agricultural migratory worker who has not qualified legally as a resident of the state and who is not, therefore, entitled to relief. Through the provision of funds by the United States Public Health Service, the State Department of Public Health is enabled to formulate a program for the hospital and medical relief of such migratory laborers. A corporation under the Farm Security Administration has been organized to provide medical and hospital care. The funds provided for this purpose will be placed in the hands of the corporation, organized under the laws of the State of California, whose board of directors consists of four governmental representatives and three representatives from the California Medical Association. This corporation will devise the essential plans for the provision of adequate medical and hospital care, legal authority for which action is in the Nonprofit Hospital Act.

Under this scheme, each of the county medical societies will be called upon to provide a panel from which the individual patient may select his own physician, who shall receive definite compensation for his services. In this manner, the fundamental principle which guarantees the right of the patient to select his own physician will be maintained. The unique feature of this plan lies in the fact that the medical profession will be called upon to furnish care for the migratory laborers and will be paid for their services. If this plan is successful, the association should extend the program so that the doctor may receive compensation for his services whenever and wherever they may be provided through governmental agencies.

This plan would make unnecessary, as well as inadvisable, the employment of government physicians or contract medicine in any form. The time has arrived when governmental agencies that are called upon to provide medical care should turn over the provision of such service to members of the medical profession. The medical profession, in turn, should use its best efforts in always furnishing high grade medical service, obviating the possibility of extension of contract medicine in any form. By spreading the burden of hospitalization over a large group, cutting down the expense of hospitalization to individuals, and permitting them to continue the right of obtaining their own private physician without dictation or interference by any governmental agency, relief of the highest order will be given to the underprivileged.

The American people, with their inborn independence, always desire to conduct their own businesses in their own way. Americans have always indicated that they desire to select a physician of their own choosing, and no European plan of medical insurance could possibly be satisfactory to our people unless the point of regimentation has already been attained. In such a case, there is no personal choice in anything.

With regard to the individual in the lowest income class, there can be no argument or quibbling over the provision of medical care. It is the unequivocable duty of governmental agencies to give these most underprivileged individuals adequate medical care free of cost, but the physician should not be asked nor expected to carry the financial burden involved. He should always be reimbursed adequately for his services.

IN CONCLUSION

Each of the topics I have discussed has a somewhat intimate relationship to governmental activities, a fact that should not be lost sight of in a consideration of trends in present-day medical practice. The old way of several decades ago, when medical organizations were only of secondary im-

portance in the lives of physicians, has passed. Today, it behooves every member of the medical profession to be fully alert, and take an active interest in organization work; because, only through united effort will it be possible for us to preserve those methods which experience has shown to be necessary implements, in making possible the highest type of medical service for the citizens of our state and nation. I thank you.

TRAUMATIC RUPTURE OF THE SPLEEN*

By Edmund Butler, M.D.
and
Walter Birnbaum, M.D.
San Francisco

Discussion *by Alanson Weeks, M. D., San Francisco; F. Paul O'Hara, M. D., San Diego.*

THIS paper is a review of twenty-one cases of injury to the spleen. Although there are many papers appearing in the literature discussing this relatively uncommon injury, it deserves renewed attention because (1) there are not a few autopsies revealing unrecognized ruptured spleen as the major cause of death, and (2) surgeons not dealing primarily with trauma fail to allot this subject its proper importance. We must constantly keep in mind the possibilities of rupture of the spleen, rupture of the urinary bladder, and rupture of other hollow viscera in every injured person.

In this series there were seventeen males and four females, whose ages averaged twenty-three years. This predominance of younger males is undoubtedly due to the fact that they are most exposed to the types of trauma necessary to cause this injury. Thirteen of these resulted from vehicular accidents, five from penetrating wounds, and three from falls.

The interval between the time of injury and entry into the hospital varied from ten minutes to twenty-four hours, while the period of observation was from fifty minutes to fifty-five hours. These intervals were prolonged in some cases because of (1) the delay by the patient in seeking medical care, (2) the time consumed in an attempt to combat shock, (3) the time required for observation and the difficulty in making the diagnosis in the presence of multiple injuries, and (4) the fact that the ruptured spleen was overlooked because of other injuries.

DIFFICULTIES IN DIAGNOSIS

The difficulties in making a diagnosis may be due to (1) the frequent absence of visible signs of injury to the anterior abdominal wall which leads the patient, and, at times, the doctor, to disregard the early mild symptoms, believing any trauma sufficient to rupture the spleen would cause visible evidence of injury to the superficial tissues; (2) the characteristic recession of symptoms, as mentioned below; (3) the presence of shock resulting from head injuries, or alcoholism interfering with the usual reaction of the patient to injury; and (4) the presence of more obvious symptoms resulting from other injury.

PAIN

Regional pain is the most important clinical manifestation of rupture of the spleen. It is often misleading in character. Pain may be of a dull, aching type, or it may be sharp and lancinating. It may be localized to left upper quadrant early, and soon generalized throughout the abdomen. Generalization occurs as the blood spreads in the peritoneal cavity. The pain is usually more intense in the left upper quadrant or left flank. Characteristically, the pain continues during active bleeding. This recurrence of pain, due to recurring hemorrhage, is partly due to the rhythmic contractions of the spleen, which gives the following cycle: A clot forms, the patient's condition improves, blood pressure rises, contraction of the viscus dislodges the thrombus, bleeding recurs, and pain and shock once more become evident. The pain is not severe, as a rule. It does not reach the intensity of that in rupture of the stomach or duodenum. It is usually relieved by small doses of opiates. It is similar to that present in the lower abdomen following a rupture of an ectopic pregnancy.

At times, radiation of pain to the shoulders and left back occurs because of irritation of the diaphragmatic peritoneum, and attention may be erroneously attracted to the chest.

REËXAMINATIONS IMPORTANT

The injury often is not suspected in the patient who is most helped by prompt surgical intervention. Hourly examination and rechecking of the findings and laboratory work in all traumatized individuals are essential. Often by the time the resident examines the patient who has been reported in shock, the bleeding has temporarily ceased and general condition has improved, thus misleading the examiner.

In all patients where there is a history of trauma to the abdomen, the flanks or the lower chest, even if there be no visible injury and no early complaint of pain, we must be spleen-minded and not overlook the slowly developing shock, the slight distention, the mild abdominal pain and slight discomfort, which are the early signs of rupture of the spleen.

Tenderness, direct and rebound, and guarding coincide with the distribution of the pain, but they may not be remarkable. Freed blood in the peritoneal cavity is seldom demonstrable, even when a considerable quantity is present, although localized dullness may indicate a confined hemorrhage in the splenic area. This local collection of coagulated blood is sometimes visible on the roentgenogram. Rectal tenderness and a soft, resisting fullness may be present due to blood in the cul-de-sac of Douglass. Temperature, pulse, respiration, and blood pressure usually are indicative to some degree of shock. The temperature is subnormal, the pulse may be elevated to 120 or more per minute. A fact, not well known, is that early in hemorrhage the

* From the San Francisco Emergency Hospital Service, San Francisco Department of Public Health.

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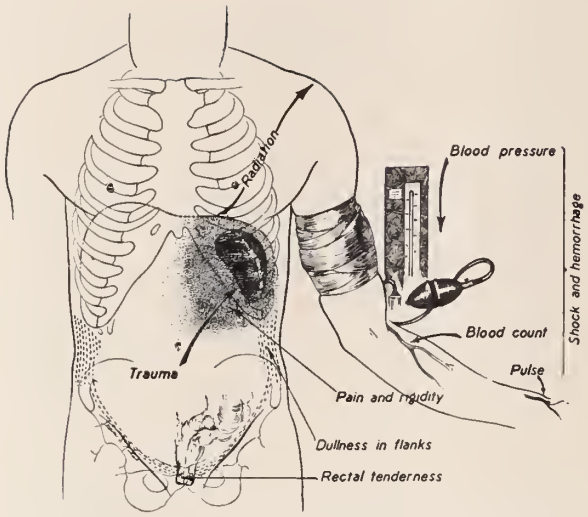


Fig. 1.—Outline of typical symptoms and findings of rupture of the spleen.

pulse slows in an attempt to encourage coagulation to lessen the amount of blood loss. The blood pressure fluctuates with the hemorrhage. The red blood cell count and percentage of hemoglobin often do not point to severe hemorrhage, but a slight gradual fall is significant. The peripheral count (ear, finger) often is deceptive because of the peripheral concentration and stasis of the blood in shock. Blood from the larger veins (the so-called "central count") is of more value. The white blood count is usually high. All but four of this series showed more than 20,000, and one 41,000 white blood cells. The polymorphonuclear count is, likewise, high. Only four in this series fell below 80 per cent, and one showed 98 per cent.

ASSOCIATED INJURIES

The majority of these patients, especially those with penetrating wounds, had severe associated injuries. In those with nonperforating injuries, five were associated with fractured skull, ribs, pelvis, femur, and forearm. One had a ruptured duodenum, one a ruptured liver, and one a ruptured kidney. It may again be emphasized that these injuries are apt to confuse the picture and draw attention to the obvious injuries, causing the symptoms of splenic injury to be overlooked.

It should not be forgotten that the spleen is within the rib-cage as well as being intra-abdominal—as are parts of the stomach, liver, and large bowel—and may be injured in penetrations of the chest. In only three of our records was any mention made of evidence of external injury in the subcutaneous splenic rupture. There may be abrasions or ecchymosis at the site of injury, but the latter, especially, is not evident at the time of early examination.

The treatment of a ruptured spleen is splenectomy. If the spleen is comminuted or completely torn from its pedicle, immediate intervention is imperative. A few hours may be disastrous. Death from exsanguination has taken place in such patients within a few hours. Ordinarily, in severe shock, it is rational not to operate upon the patient, but treat the shock first. However, if the shock is due primarily to hemorrhage from large vessels, then immediate surgery is indicated. Administration of intravenous fluids and transfusion should be reserved for the operating room or postoperative treatment. Usual quantities of intravenous fluids may so raise the blood pressure that exsanguination rapidly takes place.

EXPLORATION OF ABDOMEN

When exploring the abdomen, complete relaxation and ample incision are essential. Ether or subarachnoid block are the anesthesias of choice. The spleen must be carefully palpated. This is particularly true of palpation in the region of the junction of the pedicle and hilus posteriorly, because it is here that important injuries may escape the exploring hand. If free, uncontaminated blood is encountered it may be dipped out with a small ladle or aspirated, citrated and autotransfused. If not sufficient blood is recovered to dilute the citrate solution, normal saline may be added. Autotransfusion is at times a life-saving procedure. At operation, the spleen has been found to be ruptured in various degrees. No doubt, there are superficial tears giving few symptoms and few signs of peritoneal irritation, not often diagnosed as splenic injury, which recover rapidly with rest. The severe lacerations usually run transversely or obliquely to the long axis.

MORTALITY

The mortality in our group of patients was as follows:

Number of cases	21
Died	8
Mortality	38%
Nonpenetrating injuries	16
Died	5
Mortality	31%

Of the five that died, one also had a rupture of the duodenum; one had a ruptured spleen, which was not found at operation; two died within forty-eight hours of shock and hemorrhage; one died within ten days of peritonitis and pneumonia.

CONCLUSIONS

1. Traumatic rupture of the spleen is often not found until autopsy.
2. Many factors contribute to the frequent delays in surgical intervention.
3. Diagnosis may be difficult, although this injury presents a fairly typical course of clinical events (Fig. 1).
4. The prognosis is grave and the mortality high.
5. Splenectomy is the treatment.

490 Post Street.

DISCUSSION

ALANSON WEEKS, M. D. (384 Post Street, San Francisco).—Doctors Butler and Birnbaum's paper, presenting twenty-one cases, is certainly well worth careful consideration. The fact that ruptures of the spleen are often first found at autopsy indicates that this statement of the doctors is not analyzed as to differentiating those cases with death from splenic hemorrhage alone from those ending from associated injuries in which splenic hemorrhage was a contributory factor. Certainly, one cannot deny the need of careful examination of injured patients with the diagnosis of splenic hemorrhage in mind. In our experience the

patient does not, as a rule, show external marks which would lead one to suspect an injury of the spleen. The diagnosis is made clinically. Occasionally an injury that is apparently trivial can cause such a hemorrhage. We recall one schoolboy who jumped on a street-car. While holding an exercise book with one edge in the fold of the left elbow and the other against the flank, he received a bump on the elbow as he swung onto the car. This was sufficient to rupture the spleen. Another case, a small girl, fell off a garage roof; she received bilateral Colles's fractures and a ruptured spleen. One must, therefore, constantly keep the possibility of a ruptured spleen well in mind. When in doubt, explore. The dangers incident to a simple exploratory operation, with negative findings, are far less than the danger of overlooking some lesion, the neglect of which may be fatal.

F. Paul O'Hara, M. D. (Medico-Dental Building. San Diego).—This timely article on the very interesting subject is of an especial appeal to me, since, upon reviewing the cases of ruptured spleen in this district two years ago, I found that only one-third of the cases were diagnosed and operated upon prior to autopsy.

The difficulty of diagnosis is emphasized by the authors, and usually only a diagnosis of some ruptured viscus in the abdomen is possible. The initial shock in a ruptured spleen of any severity is out of proportion to the findings and should make one suspect the pathology. In cases that are observed longer than twenty-four hours following an injury, and in which the initial shock is overcome, the majority, if not all the cases, show a rather marked rise in blood pressure above normal, even in young people, which persists unless severe hemorrhage occurs, and lasts as long as several months following splenectomy. This interesting phenomena has not been satisfactorily explained by any investigators.

In some of the cases that I have seen, it is remarkable that the patient has gone back to his home for a period of a week or so following injury without a diagnosis being made, when the release of a blood-clot with resultant hemorrhage causes him to return with a typical picture. Another diagnostic point, which is not present, however, in all cases, is hematemesis of old blood, which possibly may occur due to the close association of the blood supply of the spleen and the stomach. The emphasis of close, continued reëxamination of these cases by the authors is to be commended, and the prompt, proper carrying out of splenectomy results in complete recovery in a surprising majority of cases. The use of autotransfusion is sometimes a life-saving procedure, but in all events transfusion or infusions should be saved until the hemorrhage is stopped by the performance of splenectomy.

IS PARESIS (DEMENTIA PARALYTICA) CURABLE?*

RESULTS IN PERSONALLY TREATED CASES

By Walter F. Schaller, M.D.
San Francisco

Discussion *by Samuel D. Ingham, M. D., Los Angeles; Benjamin W. Black, M. D., Oakland.*

THE clinical terms, general or progressive paresis of the insane, or dementia paralytica—paresis, in common parlance—given us by the older writers, describe only the final stages of this disorder, as seen in institutions and neglected cases. These terms are still applied to the earlier stages of the disease, when physical weakness or advanced mental disintegration is not evident. Our knowledge of paresis has outgrown the nomenclature, and there is need of a more descriptive term having a precise clinical and pathological foundation; however, the term is well established by usage and no descriptive terminology has satisfactorily replaced it. The disease is a pathological entity and is one of the few neuropathological conditions which may be microscopically diagnosed. To the classical description of Alzheimer [1] only a few additions have been contributed in recent years, notably the presence of the Spirochaeta in brain tissues and the characteristic iron deposits in the adventitia of the blood vessels. He had already (1904) expressed the opinion that rod cells, now classified as microglia, were of mesoblastic origin.

The usual paretic brain observed at necropsy shows a predilection of the pathologic process for the anterior parts of the brain, and thickened and adherent membranes over the shrunken cortex. Microscopically, both chronic inflammatory and degenerative cortical lesions are present. The relationship of these associated lesions has never been satisfactorily explained. Alzheimer has discussed mental symptoms in syphilitic brain lesions and classifies the nonparetic forms as vascular, gummatous, and meningiomyelitic (parenchymatous). In the latter form he particularly calls attention to the important association of the syphilitic meningitis with the essential brain changes. This writer discards the meningeal theory of paresis on the basis that in the early stages of the disease the superficial cortical lesions may be so slight and lesions in the deeper cortical layers so marked, that a causal relationship is not to be reasonably entertained. As these meningeal changes are not only hyperplastic, but also infiltrative, the reservation is made, however, that they may exert a determining influence on the manifestations of the disease.

The lack of pleocytosis in the cerebrospinal fluid, in cases where necropsy shows markedly thickened cerebral membranes, suggests that these membranes were primarily the seat of an active meningitis, and later have become sclerosed, when the active process has been arrested. If this hypothesis is valid, an appreciable pleocytosis is to be expected in the first stages of the disease, and not necessarily in the later stages. Such a condition is comparable to pathological processes observed in tabes.

A high fluid pleocytosis, associated with a paretic curve and strongly positive syphilitic serology, is frequently met with in patients with symptoms of emotionalism, nervousness, tremor, and heightened reflexes, who are often referred to a neuropsychiatrist with a Wassermann-fast blood. Symptomatology does not disturb the patient so much as consciousness of persisting syphilis. Indeed, it is quite probable that such cases, because of disregard of symptoms, often remain undiagnosed and untreated, until some definite mental or moral aberration enforces medical observation and care. Whether such early cases show a characteristic pathology of paresis is unknown, as only a chance necropsy could definitely decide this question.

If acute syphilitic meningitis affects the base of the brain, cranial nerves are involved; if it affects the cortex, lancinating headaches, tendency to somnolency, hypo-activity, and symptomatic complaints of the patient, differentiate this form from

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

paresis. The question then arises whether syphilis of the convexity may be a transient pathological state of paresis of essentially meningitic form, which, when progressive, determines paresis. Acute cases of this sort which come to the attention of the physician are generally recognized and treated, and it is further conceivable that beginning paresis may thus be aborted. Surely, paresis, comparable to the Argyll Robertson pupil, does not spring from the brain in its fully developed form, as did Minerva from the forehead of Zeus when his head was split with an axe to relieve a headache.

Pathological mutation in syphilitic brain processes, following therapy, is quite possible. It is now common knowledge that a paretic type of colloidal curve, indicating a high grade of parenchymatous involvement, may be broken down to a curve of cerebrospinal syphilis type. This will be strikingly demonstrated in the cases about to be reported.

IMPORTANCE OF PROPER THERAPY

It is not the purpose of this paper to enter into a discussion concerning the determination of paresis in an individual case, whether it is due to a particular strain of spirochaeta or to a constitutional tendency, but to emphasize that in early cases of brain syphilis which are clinically and serologically paresis, sustained and adequate therapy may effect a remarkable improvement, to the degree that the disease is arrested, and for all practical purposes, cured. This leads to a consideration of what is meant by the term "cure" in syphilis. Strictly speaking, an infectious disease process is cured only when the infective agent is definitely eliminated. This would postulate, therefore, negative tests for syphilis in symptomatically arrested patients observed over a considerable period of time. The term "cure" may be used properly, I believe, in cases which show no symptomatic effects, in so far as can be determined, even in the presence of serological signs of syphilis in attenuated form. Recovery is perhaps a better term. It may be this latter use of the term on which certain institutional statistics have been given us. I would particularly refer to a report on the treatment of dementia paralytica by the Mental Hospitals Committee of the London County Council [2] of 1936. It was pointed out in this report that before the advent of modern therapy there was no real recovery from the disease. In the six years from 1930-1935, inclusive, 1,914 cases were treated with modern methods. This series was compared with 2,545 cases in a six-year period, from 1908-1913, inclusive, when modern treatment was not in use. A comparison shows that in cases treated by modern methods the mortality rate had been halved, one-fifth of the cases had been discharged, the cure in the majority being permanent, and many of the persons discharged had filled positions of responsibility.

TREATMENT

It is questioned whether any fixed therapeutic regimen can be laid down for general application. The patient, as well as the disease, must be considered and studied. From the standpoint of the patient, maintenance of weight, general physical condition, and tolerance and response to given remedies must ever be borne in mind. Anemia, infections, and concurrent debilitating factors or habits must be combated and, if possible, removed. Alcohol should be proscribed or taken in extreme moderation. Exhaustion and fatigue are to be avoided. Whereas such general indications of therapy appear obvious, there is danger of neglecting the patient by treating the disease only, expressed by positive serology, and to base indications for treatment principally on the latter findings. Because of such considerations it has been our practice to administer interrupted, rather than continuous, treatment. It is desirable, however, to make a complete serological check after each course of treatment.

Malaria, in my experience, has proved the most efficient remedy in paresis, for there is fair evidence, according to the investigations of Breutsch [3] and others, that malaria exerts a favorable biological action in addition to the hyperpyrexia. In a number of my cases malarial therapy has been repeated; in one case the malaria was mistakenly believed to be terminated, and the patient carried the latent infection over a period of months. Hyperpyrexia, by hot baths, has been used in a few cases as a substitute for malarial treatment. Other means, as by typhoid vaccine, hot-air baths, and blanket packs, have been reported as giving satisfactory results.

Next to malaria in therapeutic efficiency, I place intraspinous therapy, and the modification of the Swift-Ellis treatment devised by the late Doctor Mehrtens, is used. Although less technical methods have largely replaced this form of therapy, it has a deserved and established place in the special armamentarium of treatment of this disease. Tryparsamid is a particularly valuable remedy in conjunction with malaria or fever therapy. In doses of one gram once or twice weekly, it is a comparatively safe remedy if ordinary precautions are taken in the initial doses to note either subjective or objective involvement of the optic nerve. It is not a remedy, however, that is applicable to each and every case; cases have been observed in which results have been disappointing in the failure of the patient to respond with the usual increase in appetite and weight and sense of well-being, and improvement of serology. Patients may even react unfavorably to this drug.

Heavy metal therapy is now chiefly represented by bismuth. I favor iodobismitol, which carries in combination iodin, a remedy formerly highly regarded in neurosyphilis, but undeservedly fallen in disuse. The same may be said of mercury; indeed, mercury, the iodids, and a sea trip, were the chief measures used in neurosyphilis before the advent of arsenical remedies, and not without benefit in a proportion of cases.

The arsphenamins are of value in cases where the meninges are permeable to these drugs, which permeability is in the neighborhood of 40 per cent. Their efficiency can be objectively determined by the serological response and the effect on a high fluid pleocytosis.

CASE 1.—*Chart of Treatment and Tests*

Treatment	Date	Tests				
		Leukocytes	Globulins	Colloidal Gold	Wassermann Fluid	Wassermann Blood
Three years' general treatment immediately preceding observation	Aug. 18, 1923	10	Nonne + Noguchi +	5554433210	1.0 0.5 0.3 0.1 ++++ ++++ ++++ ++++	+++
August to October, 1923, ten intraspinous treatments; intramuscular mercury salicylate to tolerance	Oct. 26, 1923	6	Nonne + Noguchi +	5555554321	1.0 0.5 0.1 0.025 +++ +++ --- ---	
November to December, 1923, eight tryparsamid injections, 1.5 to 3 grams	Dec. 4, 1923	3	Nonne + Noguchi +	4455431000	+++ +++ --- ---	
December, 1923, to March, 1924, rest period						
March to May, 1924, eight tryparsamid injections; March to July, 1924, mercury salicylate; marked paranoid ideas	May 7, 1924	2	Nonne + Noguchi +	5555554321	+++ +++ --- ---	
July to September, 1924, rest period	Sep. 11, 1924	2.5	Nonne tr. Noguchi tr.	5554321000	+++ +++ ++- ±--	
September to December, 1924, ten intraspinous treatments; mercury salicylate	Dec. 5, 1924	7	Nonne tr. Noguchi tr.	3334421000	+++ ++- --- ---	
December, 1924, to April, 1925, rest period; paranoid ideas in modified form	Apr. 23, 1925	1	Nonne + Noguchi +	5555553210	+++ +++ --- ---	+++
April to August, 1925, nine tryparsamid injections; bismudol intramuscularly	Sep. 3, 1925	1	Nonne sl. tr. Noguchi sl. tr.	1223210000	+++ ±-- --- ---	---
August to December, 1925, rest period; mentally clear						
December, 1925, to January, 1926, eight tryparsamid injections	Jan. 14, 1926	1	Nonne + Noguchi +	3334542100	++- --- --- ---	---
January to December, 1926, rest period	May 14, 1926	—1	Nonne tr. Noguchi tr.	3233210000	+-- --- --- ---	
December, 1926, to January, 1927, nine tryparsamid injections	Jan. 19, 1927	2	Nonne + Noguchi –	3333321000	--- --- --- ---	
January to February, 1927, malaria; rest period	Jul. 12, 1927	2.5	Nonne tr. Noguchi tr.	2223211000	--- --- --- ---	---
September to December, 1927, bismudol; December, 1927, to September, 1928, rest period	Aug. 18, 1928	—1	Nonne tr. Noguchi tr.	2222211000	--- --- --- ---	---
September to November, 1928, sulpharsphenamin, bichlorid injections	Jun. 21, 1929	—1	Nonne tr. Noguchi –	1123221000	--- --- --- ---	---
All treatment discontinued	Feb. 18, 1937	38	Heavy trace	Negative	--- --- --- ---	---

In the serological control of medication a therapeutic response is considered favorable if a spinal fluid pleocytosis is reduced, the colloidal gold curve broken from paretic to middle-zone type, and the Wassermann reaction modified. If this serological improvement is effected with an associated improvement in the patient's mental and physical condition, we may confidently proceed in the majority of cases with the expectancy that the disease may be controlled and that a cure is possible. It is not contended that advanced cases with irreparable brain damage and atrophy, presenting marked dementia and debility, can ever be restored to normalcy by any treatment. However, even in such cases remarkable improvement may occasionally be observed.

REPORTS OF CASES

For obvious reasons, it is notoriously difficult to keep paretics under observation and treatment for any considerable period of time, except by an institutionally controlled regimen. Comparatively few extramural cases, therefore, have been followed a sufficient length of time to evaluate the final result of prolonged and intensive treatment. Frequently, after an initial satisfactory therapeutic response, these patients, with their characteristic optimism and lack of judgment, resist further treatment, and are, therefore, afterward inadequately treated or pass entirely from observation. Of those few cases in a considerable number, however, which have fulfilled the requirements of adequate, controlled therapy over a long period of time, four are here reported.

CASE 1.—Observation of thirteen years. A male rancher in the fourth decade was first observed in August, 1923, with symptoms of euphoria, impaired memory, mood changes, mental confusion, and paranoid ideas. His infection occurred ten years previously, following which he was inadequately treated. In the three years before consulting me, thirty to forty intravenous injections of arsphenamin had been administered; he was also given mercury. The physical and neurological examination was not remarkable, save for lack of pupillary light reaction and exaggerated tendon reflexes. His blood Wassermann was strongly positive. An analysis of the cerebrospinal fluid showed ten leukocytes per cubic millimeter, globulin increased, the

colloidal gold curve read 5554433210, the Wassermann reaction was positive in all dilutions. On hospitalization he was uncoöperative, demanded his release, and was only retained in the hospital by a ruse. Therapy was commenced by a series of ten weekly intraspinous treatments. After the fourth treatment some mental betterment was noted. Following this series of intraspinous treatments, the serology showed but little change, the colloidal curve remained paretic in type. During the period of intraspinous therapy he was also given intramuscular mercury salicylate to tolerance. In November, weekly injections of tryparsamid in one and a half to three-gram doses were commenced, and eight doses administered up to the end of 1923. In December, the first definite serological improvement was noted, the Wassermann reaction was negative in amounts of fluid less than 0.5 cubic centimeter, the colloidal gold curve was 4455431000. A mental rating at this time showed a mental age of 13.4 years, with obvious deterioration; comprehension of new situations was especially poor; the patient still showed paranoid tendencies and ideas of grandeur. He had spells of nervousness and excitability over small matters.

In the early part of 1924, after a rest period, he was given injections of leukocytic extract (Squibb), and from March to May eight injections of tryparsamid, one and a half grams each, and fourteen weekly intramuscular injections of mercury salicylate, one grain each, from March to July, when he developed a stomatitis. During this period considerable difficulty was experienced with the patient, who had left the hospital, because of paranoid ideas; threatening letters sent to former business associates were considered grounds for commitment by legal action, which, however, was deferred. These persecutory notions were such that the patient believed his life endangered, and would elaborate on experiences which showed marked ideas of reference in ordinary life situations. From September to December, 1924, he was given a second series of ten weekly intraspinous treatments, and with each treatment an intramuscular injection of mercury salicylate. The colloidal gold curve, which had remained paretic in type during the major part of this year, reverted in December to a middle-zone type, when the reading was 3334421000. In the beginning of 1925, paranoid ideas still persisted in modified degree; from April to August he was given intramuscular Bismudol [4] and nine tryparsamid injections; the colloidal gold curve again became paretic in type in April, but cerebrospinal in type in September, when the blood Wassermann first became negative and remained so permanently; he appeared mentally clear. In the early part of 1926 the Wassermann reaction in the fluid was only one plus in 1.0 cubic centimeter of fluid, and subsequent fluid Wassermanns were consistently negative. During this year the patient received but eight injections of tryparsamid in doses of one and a half grams. He had become mentally stabilized.

In the beginning of 1927, although the blood and fluid Wassermanns were completely negative, the colloidal gold curve read 3333321000. Five additional tryparsamid injections were given in January, after which he was given a course of malarial therapy. A recurrence of chills and fever followed temporary interruption of the disease by quinin. The malaria left the patient quite depressed and ill. In July his colloidal gold curve read 2223211000, and thereafter never reverted to the paretic type. From September to December, 1927, he was given bismuth injections. In the latter part of 1928 he received a course of intramuscular bichlorid and sulpharsphenamin, which latter remedy was poorly tolerated.

In June, 1929, the serology remained negative throughout; the colloidal gold curve read 1123221000. As the patient had made a mental and serological recovery, treatment was discontinued, his serology having been negative for approximately two years. He had successfully resumed occupation as a rancher, and has continued in a good state of physical and mental health up to the present. In February of this year, 1937, serological tests were repeated. The blood and fluid Wassermanns were negative, also the colloidal gold test. The globulins were reported, however, as a heavy trace, the leukocytes 38. In the light of the patient's lack of symptoms or complaints, and his occupational efficiency, I was inclined to regard these latter findings as a slip in laboratory technique. In any event, after an intensive, controlled therapy for five years, serological tests for syphilis have been negative for ten years, and no treatment has been given for eight years, during which last period there has been no recurrence of symptoms. In all, twenty-five cerebrospinal fluid examinations were made, which examinations were facilitated by the number of intraspinous injections. The tabulated list of these analyses showed a marked serological improvement following two years of intraspinous therapy and associated treatment by tryparsamid and mercury. The mental improvement fairly paralleled the serological improvement. Malaria was administered only after the disease had been controlled. This case well illustrates the interrupted type of treatment.

* * *

Case 2.—Observation of eight years. A business man in the late twenties acquired his infection in 1918. He had been treated following his initial lesion, and also for six months prior to coming under my observation in October, 1928, by arsphenamin and heavy metals. The examination revealed tremor, marked stumbling over test phrases, left facial lagging, lively tendon reflexes, slowing of cerebration and poor digit memory. The clinical diagnosis was paresis, which was verified by serological tests: The blood Wassermann was strongly positive; cerebrospinal fluid Wassermann was also positive in all amounts of fluid tested; there were seven leukocytes per cubic millimeter, the colloidal gold curve read 4434342100. Following the lumbar puncture there was considerable mental excitement and confusion. Therapy was instituted by malarial inoculation; the malaria was interrupted on December 17, 1928, after the eighth paroxysm, because of shock and collapse; the fever registered 108 degrees Fahrenheit by rectum. Toward the end of January, 1929, after upbuilding by iron in the form of Blaud's pills, he showed a remarkable improvement; tremor, previously marked in both hands, ceased in the right hand, digit memory had improved, and he was emotionally stable. From February to May, 1929, he received thirteen intramuscular injections of one and one-half grains of bismudol. In June his colloidal gold curve reverted to a middle-zone type, the fluid Wassermann reaction was less strongly positive. Eight intraspinous treatments were given from June to October; at the conclusion of this series the colloidal test read 1122110000, the fluid Wassermann reading was essentially the same as in the previous test, the blood remained strongly positive. Directly following intraspinous therapy he was given a course of intramuscular sulpharsphenamin and bismuth to the end of the year. Following this intensive treatment, covering a period of somewhat over a year, he was given a rest period, then reinoculated with quartan malaria on May 15, 1930. The temperatures in a number of the paroxysms attained 105 [4] degrees Fahrenheit by mouth. In all, he had six paroxysms. In October, 1930, iodobismitol [5] was begun in 2 cubic centimeter intramuscular injections twice weekly; this was continued until the last of April, 1931; in all, forty-two such injections were given in the series. In August, 1931, the spinal fluid Wassermann was reported faintly positive, the colloidal gold curve was of the middle-zone type, not attaining a higher figure than 2. The blood remained positive. From August, 1931, to April, 1932, he received twenty-six injections of iodobismitol, two cubic centimeters each. At the conclusion of this series the patient was mentally stable and had resumed occupation. He did not report to the office for three years. In June, 1935, a cerebrospinal fluid test was negative throughout, the blood Wassermann gave an anticomplementary reaction. A further series of twenty injections of iodobismitol was administered. In September, 1936, the fluid was again entirely negative; the blood Wassermann anticomplementary, as before; titration revealed it suspiciously positive. He was then given eight injections of neoarsphenamin with instructions to report at future intervals for Wassermann tests. The last status showed no mental disturbance, no tremors, no emotional instability. At the present time he is successfully employed.

In this case the therapeutic attack was chiefly by means of malaria, and by bismuth in conjunction with iodin. From October, 1930, to April, 1932, he received a total of sixty-eight injections of iodobismitol in two cubic centimeter doses. There was a striking and persisting improvement after the first malarial inoculation. Comparatively little arsenical treatment was employed in this case. Tryparsamid was not given.

CASE 2.—*Chart of Treatment and Tests*

Treatment	Date	Leukocytes	Globulins	Colloidal Gold	Wassermann Fluid	Wassermann Blood
	Oct. 11, 1928	7	Nonne trace	4434342100	0.1 0.3 0.5 1.0 ++ ++++ ++++ ++++	++++
November, 1928, malarial inoculation February to May, 1929, bismuth injections						
	Jun. 20, 1929	4	Nonne neg. Noguchi neg.	2233321000	1.0 0.5 0.1 0.025 --- --+ +++ +++	
June to October, 1929, eight intraspinous injections	Oct. 22, 1929	9	Nonne neg. Noguchi neg.	1122110000	--- -++ +++ +++	+++
October to December, 1929, sulpharsphenamin, bismuth injections; rest period	Jan. 4, 1930					+++
May 15, 1930, malarial inoculation						
July to October, 1930, rest period	Jul. 22, 1930					+++ ++- +--
October to December, 1930, iodobismitol, 2 cubic centimeters twice weekly						
	Jan. 14, 1931	3	Nonne neg. Noguchi neg.	5444421000	--- --- -++ +++	+++
December, 1930, to May, 1931, iodobismitol May to August, 1931, rest period						
	Aug. 18, 1931	1	Nonne neg. Noguchi neg.	1222100000	--- --- --- -++	+++
August, 1931, to April, 1932, iodobismitol; mentally stable, at occupation						
	Jun. 14, 1935	2	Nonne neg. Noguchi neg.	1122110000	--- --- --- ---	Anticomplementary positive (?) on titration
June to October, 1935, iodobismitol						
	Sep. 19, 1936	2	Globulins trace	Negative	--- --- --- ---	Anticomplementary +++ on titration
September to November, 1936, neoarsphenamin, eight injections						

CASE 3.—Observation of nineteen years. A business man in the thirties was infected fourteen years previously and treated over a period of five years. The Wassermann reaction in the blood had been repeatedly negative prior to consultation with me in 1918, and but little specific therapy had been administered in recent years. He complained of neuritic-like pains in the legs. The neurological examination showed hyperactive reflexes, inversion of the right triceps reflex, and some disturbance of deep sensation in the left lower extremity. The clinical diagnosis was preataxic tabes. The Wassermann reaction in the blood at this time was positive. The cerebrospinal fluid Wassermann was also positive in 0.5 cubic centimeter of fluid and over; there were seventy-five leukocytes per cubic millimeter of fluid. The patient was not seen again until ten years later. In the interval he had been insufficiently treated, and no serological tests of the cerebrospinal fluid had been made. He complained at this time of extreme nervousness and tremor. The examination showed a suggestive Romberg, absent ankle jerks, fixed and myotic pupils, and tremor of the hands and tongue. No mental deterioration or psychotic symptoms were evident. The impression was an early form of taboparesis, which was confirmed by a serological recheck on the cerebrospinal fluid, which read: Leukocytes 45 per cent cubic millimeters of fluid, colloidal curve 5555431000, fluid Wassermann positive in amounts greater than 0.025 cubic centimeters. Six intraspinous treatments were given at intervals varying from one to two weeks. These were followed by severe constitutional reactions. Following the fifth treatment there was a slight apoplectiform seizure of the left extremities with increased reflexes on the affected side. After the intraspinous series the cerebrospinal fluid (May 29, 1928), showed a reduction of leukocytes to 24 per cubic millimeter of fluid, the colloidal gold curve read 3334321000, an indication of a break to a cerebrospinal type of curve. The fluid Wassermann remained unchanged. He was given thirty grains of potassium iodid daily. From June to November, 1928, sixteen weekly intravenous injections of one gram each of tryparsamid were administered, and during this period he was also given weekly intramuscular injections of bismudol, the dose varying from one and one-half to three grains each. A rest period was then prescribed until the latter part of March, 1929. In January, 1929, the cerebrospinal fluid tests showed marked improvement; there were but three leukocytes per cubic millimeter of fluid, globulins were within normal limits, the colloidal gold curve read 1121100000, and the fluid Wassermann reaction was positive only in amounts of fluid greater than 0.5 cubic centimeter. Clinical improvement was marked, tremor and nervousness were much less. From March to May, 1929, seven intramuscular injections of sulpharsphenamin of two-tenths gram each were given, then a rest period followed until November. From November, 1929, to February, 1930, three intraspinous treatments were given, and also sulpharsphenamin intramuscularly, following which the cerebrospinal fluid analysis remained unchanged. During the remainder of 1930 and 1931, heavy metal therapy, bismuth and mercury, was given, with frequent rest intervals; in all, but eighteen intramuscular injections were given in

this period. In March, 1932, there were no subjective complaints, tremor had disappeared, save for a slight coarse tremor of the protruded tongue. The reflexes, including pupillary reflexes, were unchanged, except for greater activity of the patellar reflexes. The cerebrospinal fluid serology remained practically the same, the blood Wassermann was slightly positive. From this time on intramuscular iodobismitol, in series of twenty injections two cubic centimeter doses each, twice weekly, has been given yearly to date. Each year a serological check has been made. The blood Wassermann became negative in 1933, and has remained so; likewise, the cerebrospinal fluid analysis this year (1937) was reported entirely negative for the first time. The patient is symptom-free of neurosyphilis, no further objective signs have developed, and he is occupationally fit. *In this patient it is significant to note that grave symptoms of central nervous system involvement developed during a ten-year period of insufficient treatment, during which time the initial pleocytosis of the fluid had receded.*

* * *

Case 4.—Observation of nine years. A lineman in the early thirties contracted his infection in 1920, following which he was treated for a period of eighteen months. In 1928 he entered a Veterans' Hospital because of a nervous breakdown, characterized by inefficiency in his work, lethargy, and forgetfulness. The records of the Veterans' Hospital state: He "received five injections of sulpharsphenamin and three of tryparsamid, also eight injections of mercury intramuscularly. On June 26, 1928, his blood Wassermann was positive, spinal fluid was positive, cells 21, gold curve 5555555431. He was inoculated with malaria on October 7, 1928, had fifteen paroxysms, maximum temperature 105 [6]. In view of the fact that he was taken out of the hospital against advice, we have no additional serological data."

The patient came under my care in November, 1928, at the request of his employers. The examination revealed a nervous-appearing man, with but little appreciation of the serious nature of his condition, and anxious to return to work. Vasomotor changes were marked in the extremities. Tendon reflexes were hyperactive, save for his ankle jerks. The left ankle jerk could not be definitely elicited. The general physical and neurological examination was otherwise quite negative, showing no abnormalities of pupils or the neuromuscular system. There were no tremors. A slight but characteristic euphoria was present, but no frank psychosis. The blood reaction at the time of this examination was strongly positive. He was given a course of eight weekly bismudol injections and kept under observation. In December, 1928, his cerebrospinal fluid serology was still strongly positive and of paretic type, but the cell count had dropped to three cells per cubic millimeter of fluid. From March to May, 1929, he was given weekly intramuscular injections of four-tenths gram of sulpharsphenamin; this was followed by eight weekly intramuscular injections of bichlorid of mercury, and a further course of eight sulpharsphenamin injections was given up to the end of 1929. During this year his condition, both physically and mentally, showed a distinct improvement. He had returned to ground work at his former occupation. In January, 1930, the blood Wassermann was reported negative, and thereafter remained so. The cerebrospinal fluid test showed two leukocytes per cubic millimeter, an increase in globulins, a persisting paretic type of curve, and a strongly positive Wassermann. A rest period until July, 1930, was followed by ten intravenous injections of tryparsamid and fourteen intramuscular injections of iodobismitol, two cubic centimeters each. In December, 1930, the cerebrospinal fluid showed no essential change. In 1931, a course of twelve sulpharsphenamin injections was given up to April; then followed a rest period of six months. Intramuscular injections of bismuth, alternating with iodobismitol, were resumed from September to December, nine injections in all. The cerebrospinal fluid analysis in December, 1931, still showed no appreciable change. Physically and mentally the patient appeared stable, tests of digit memory showed normal responses. At this period the question arose as to whether this patient might return to his original work as splicer, which necessitated working aloft. The company took the position that a man who had neurosyphilis could not ever be considered a good risk in a hazardous occupation. However, in view of this excellent occupational record and satisfactory response to treatment, he was permitted a trial, and has since been continuously working aloft as a splicer. From December, 1931, to July, 1932, there was a rest period. He was then given eight intravenous injections of silver salvarsan of two-tenths gram each. This was the only therapy administered during 1932. In January, 1933, the cerebrospinal fluid colloidal gold curve broke to a middle-zone type: 1123210000. The fluid Wassermann remained unchanged. During the year he was given two courses of iodobismitol of eight injections each. A cerebrospinal fluid test in June, 1934, showed the serological tests unchanged. During this year he received but eight injections of iodobismitol, commencing in June. In June, 1935, the Wassermann reaction in the fluid was positive only in 0.025 cubic centimeter of fluid; in this year he was given two courses of iodobismitol of eight injections each. In July, 1936, the cerebrospinal fluid showed a slight increase in the colloidal gold reaction, which still maintained a middle-zone curve; also a slight increase in the Wassermann reaction. In 1936, from July to October, he was given a course of twenty Bismarsen [6] injections of two-tenths gram each, intramuscularly. In April, 1937, the cerebrospinal fluid Wassermann was positive in 0.25 cubic centimeter of fluid, globulins two plus, there were three leukocytes per cubic millimeter, the colloidal gold curve read 0123210000. This patient is free of symptoms. He has remained continuously at work, with an excellent record of occupational performance. At his suggestion, improvements in tools used in his work have been adopted by his employers.

SUMMARY AND CONCLUSIONS

The present state of our knowledge regarding the nature and treatment of paresis is briefly reviewed. It is suggested that meningitis of the convexity is an important pathogenetic factor in the determination of this particular type of neurosyphilis.

Early stages of the disease are characterized by an appreciable pleocytosis and signs of meningoparenchymatous irritation, without evidence of any marked organic changes of essential brain tissue.

Detailed treatment of four cases—two well developed and two beginning paretics—is here reported, the duration of treatment and observation covering periods of thirteen, eight, nineteen, and nine years, respectively.

The typical fluid serology of paresis in three of these cases has been rendered negative by intensive treatment, and has remained so, with corresponding relief of symptoms for a sufficient length of time to justify the claim of a cure.

The remaining case, although not completely cleared serologically, has been transmuted to a benign cerebrospinal type.

All of these patients are symptom-free and occupationally active.

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4. Bismudol (Metz), Bismuthphenylformitate, 3 grains.

5. Iodobismitol (Squibb), Sodium Iodobismuthite Compound.

6. Bismarsen, D. R. L. (Abbott), Arsenic and Bismuth.

DISCUSSION

SAMUEL D. INGHAM, M. D. (727 West Seventh Street, Los Angeles).—The title of this paper suggests two possible answers corresponding to two different aspects of the question. If cure is considered to be a complete eradication of all the living organisms of syphilis from the body, we are not yet in a position to answer the question in the affirmative. If, on the other hand, we consider the question from the clinical aspect, we may be justified in stating that paresis can be cured symptomatically, even if it cannot be demonstrated that all the spirochaete of syphilis have been destroyed.

Accumulating statistics are impressive in demonstrating the fact that the modern treatment of paresis gives a higher percentage of better remissions than has ever been accomplished in the past. Of the modern methods of treatment, fever therapy is preëminent. There is still some difference of opinion in regard to the efficiency of artificial fever as compared with malaria, but I am inclined to favor the artificially induced hyperthermia for two main reasons: first, that the temperature reaction is entirely controllable at the will of the operator; second, the treatment is less exhausting to the patient and does not cause anemia—in fact, patients often gain in weight and improve physically during a course of treatments. There seems to be a definite correlation between the height of the temperature attained during the treatments and the success which follows. A series of treatments in which the temperatures are more than 106, or even 107 degrees Fahrenheit, are often necessary for best results.

Of the available drugs, bismuth has to a large extent superseded mercury. Tryparsamid is generally accepted to be the best form of arsenic. Alternate courses of intramuscular bismuth and intravenous tryparsamid are commonly used after a course of fever therapy as a matter of precaution even when the remission is already established.

The duration, as well as the character, of the remissions following modern treatment are better than the spontaneous remissions. The longest observation I have made is in the case of a patient who was given the malaria treatment twelve years ago, and has been working continuously in a responsible position and with a number of promotions in a large corporation over a period of twelve years. A recent patient treated in the acute stage received twelve fever treatments; maximum temperature, 108 degrees Fahrenheit; prompt remission; returned to work about two months after termination of treatments. The patient has continued to work with full efficiency and has received promotions since his recovery.

It seems to me that the best clinical evidence of curability of a disease like paresis is the promptness and the duration of recovery. Judged by this standard, early paresis is curable in a high percentage of cases.

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BENJAMIN W. BLACK, M. D. (Highland Hospital, Oakland).—The paper presented by Dr. Walter F. Schaller is a distinct contribution to the newer concepts of the dreaded disease, paresis. Having his own study of these cases in mind, Doctor Schaller stresses the term "paresis" to apply only to late manifestations, and properly makes the point that the entity under consideration does not spring from the brain in its fully developed form, with the observation of the new pathology in which the questions arise whether there is a transient pathological state of paresis, when essentially in the early form it presents the signs of meningococcic parenchymatous irritation. It is an interesting observation, particularly when it presents at this stage of the disease no marked organic changes of essential brain tissue. It is also of great interest, and stress should be placed on the statement that paresis at this stage may be aborted.

Many clinicians have long recognized the stage in the diagnosis; it seems not unusually difficult, but the important thing about the discussion would make clinicians conscious of the opportunities presented for beginning treatment which must be long continued.

Doctor Schaller has presented a series of cases showing in great detail his observation, diagnostic procedures, as well as treatment rendered over a period of as many as nineteen years. He has shown remarkable results, as all of the patients presented are symptom-free at this time and are occupationally active. An optimistic note in the treatment of this dreaded disease creeps through the discussion of these patients and their care. This, too, indicates much more than the paper would indicate: the painstaking attention given, the careful treatment provided, and the necessary arduous task of follow-up over this long period of time. Doctor Schaller has made a distinct contribution to the literature in the preparation of this paper; and to all who are concerned with the treatment of such cases as well as their early diagnosis, it should be a source of encouragement and at the same time it should point to a demand for early diagnosis and continued prolonged treatment. I am glad to have had the privilege of discussing this important paper.

THE TREATMENT OF TYPHOID FEVER IN CHILDREN, BY MEANS OF LYSED VACCINE

By J. M. FRAWLEY, M.D.
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DISCUSSION *by K. F. Meyer, Ph. D., San Francisco; Gregory Shwartzman, M. D., New York City; C. O. Mitchell, M. D., Fresno.*

TYPHOID fever is a disease of considerable mortality. In sixty-five cases admitted during the past ten years to the Fresno General Hospital there were eight deaths, a mortality rate of 12.3 per cent. Any measure which offers assistance in the treatment of this infection, therefore, merits consideration. Much attention is being given at present to biological therapy. The use of vaccine in typhoid began with Wright in 1898. In the preparation of Wright's vaccine, cultures of typhoid bacilli are killed by heat. It has recently been shown that the use of heat and chemicals as a devitalizing agent in the preparation of vaccines brings about denaturation with resultant loss of antigenic activity.[1] Vaccines in which this denaturation is reduced have been prepared by various methods.

TWORT-D'HERELLE STUDIES

In 1916-1917 Twort and D'Herelle introduced bacteriophage. Its chief use was in infections caused by bacillus of dysentery, staphylococcus and colon-group infections of the urinary tract.

There has been considerable discussion as to the nature of the lytic principle responsible for the Twort-D'Herelle phenomenon. It was at first thought that it was a living parasite of bacteria, alive and ultramicroscopic. Northrop and Krueger,[2] however, showed that it obeyed definite mathematical laws, and was in effect a chemical substance related to enzymes. The mechanism of bacteriophage activity is thought to be either through the propagation of bacteriophage in the blood stream, with resultant lysis of bacteria, or through the tissue response to the antigen released from the bacteria of lysis. Krueger, Lich, and Schulze [3] found no evidence of increase in the bacteriophage titer of the blood serum following the injection of bacteriophage. Moreover, the amount of bacteriophage present was wholly insufficient to induce bacterial lysis. Therefore, they concluded

that, since bacteriophage lysates do not act through their bacteriophage content in the septicemias, the antigen fraction alone must be responsible for the therapeutic successes reported.

OTHER ANTIGEN STUDIES

Di Christina and Caronia, in 1916 and 1917, introduced another method of obtaining antigens without appreciable denaturation by inducing lysis of the organisms with immune serum. This type of antigen has chiefly been used in the treatment of typhoid and related infections.

Lysates obtained by both of these methods contain considerable quantities of materials capable of inducing marked nonspecific response of the immune mechanism. Included in this group of materials are metabolites resulting from bacterial growth, the nutrient constituents of the media, both groups being in addition to the possible specific antigens released by lysis. Consequently, it is impossible to differentiate between the effect produced by the specific antigen and those produced by the nonspecific protein which accompanies it.

LYSED VACCINE USED BY THE AUTHORS

Lysed vaccine of the Caronia type made by Dr. Karl Meyer of the Hooper Foundation, University of California, was used in the series of cases which forms the basis of the present paper.

The method of preparation is as follows:

Using a liquid medium, a culture is made from various strains of Eberth's bacillus, the typhoid organism. To every 100 cubic centimeters of this culture, 5 cubic centimeters of typhoid convalescent blood is added. The temperature is then held at 37 degrees centigrade until lysis of all, or nearly all, the bacteria is accomplished. When the liquid portion of the culture becomes clear, this is separated from the sediment, phenolized and used as vaccine. In this way most of the bacilli which have matured, together with those which are on their way to maturity, undergo lysis because of the influence of the added serum. In this way, also, there is created a vaccine of high concentration with a constant titer, and ready for use. Moreover, the vaccine is almost free from deleterious elements.

The method of administration is as follows:

Five-tenths to one cubic centimeter of adrenalin (1 to 1,000) is injected intramuscularly. Following this, 0.5 to 0.7 cubic centimeter for an adult, 0.2 to 0.5 cubic centimeters for a child, of lysed vaccine is given intravenously. The temperature, pulse, and respiration are recorded every two hours for the ensuing twenty-four hours. A second injection of vaccine is given on the alternate day, using the same technique except the injection of 0.4 to 1.0 cubic centimeter of lysed vaccine. Subsequent injections of 0.6 to 1.0 cubic centimeter of lysed vaccine given intravenously may be administered on alternate days.

This technique was followed in the case of four children seen at various stages of typhoid.

REPORT OF CASES

Case 1.—The first patient was a girl of seven years, Edith D. The infection became evident on February 3, when she was taken to Dr. E. J. Pratt of Lemoore. Her temperature at this time was 103.4 degrees Fahrenheit, rose the next day to 105.2 degrees Fahrenheit, and remained at this level. During the next week the blood culture was taken by the State laboratory, and found to be positive for typhoid. The lysed vaccine was obtained from the Hooper Foundation, and the first injection of 0.2 cubic centimeter was given intravenously on February 9. Adrenalin 1.0 cubic centimeter of 1 to 1,000 was given simultaneously with each injection. There was no great reaction and not much change in temperature. The second injection was given on February 11, 0.4 cubic centimeter intravenously. The temperature rose quickly to 107 degrees Fahrenheit, then quickly dropped to normal on the 13th. It remained normal during the next ten days and a general improvement was noted in the patient's condition. There were no toxic symptoms. About the 20th, the temperature rose again to 103 degrees. For another ten days the temperature continued to fluctuate from normal in the morning to 102 or 103 degrees by afternoon. The general condition, however, was better. The patient was bright and cheerful. By the first of March the fever dropped and there was no further elevation.

* * *

Case 2.—During this same period the brother of patient No. 1, Edwin D., a boy of nine, was in bed with typhoid. The parents had been unwilling to give lysed vaccine to both of the children, and for this reason the boy might be considered as a control. His fever began on January 10, three weeks before his sister became ill. His infection was severe, and the temperature progressed to a high level, reaching a daily maximum of 103 degrees Fahrenheit for six weeks. After six weeks of high fever there was a remission for one week. The clinical picture, however, did not improve with the drop in temperature, and he was irrational most of the time. At the end of one week the temperature began to rise again and went back to the old level of 105.2 degrees Fahrenheit. He now showed great emaciation, his abdomen was distended and tympanitic. His condition at this time was considered very grave. On the 13th of March, two months after the onset of the disease, it was decided to institute treatment with lysed vaccine; at the same time he was given subcutaneous injections of whole blood from the sister who had now been afebrile for two weeks. During the next week three injections were given. The vaccine was given in small doses of 0.2 to 0.4 cubic centimeters, along with 5 to 10 cubic centimeters of immune blood. By March 31, one week after instituting treatment, the temperature was normal and remained normal from then on. His recovery was rapid and uninterrupted.

* * *

Case 3.—Ellis T., age ten years, was admitted May 17 with a tentative diagnosis of poliomyelitis and a temperature of 103.6 degrees which went to 104 degrees Fahrenheit. The following day the temperature had come down to normal, but on May 29 it rose again to 105 degrees and went as high as 106, with an average daily range from 100 to 103 degrees during the next two weeks. The blood culture was positive for typhoid. The white blood cells numbered 6,700; red blood cells, 3,440,000; polymorphonuclears, 35 per cent; small lymphocytes, 5 per cent; large lymphocytes, 50 per cent; eosinophils, 4 per cent. Spinal fluid, one cell. Widal negative. On June 9 the first injection of lysed vaccine was given, 0.5 cubic centimeter, and the temperature rose within four hours to 106.0 degrees. The next day the temperature in the morning was 100 degrees, and in the afternoon was 102. On June 11 the second injection of lysed vaccine was given, 1.0 cubic centimeter. The next day the temperature dropped to normal, and remained normal until the child was discharged two weeks later.

* * *

Case 4.—Consuela C. was admitted December 9 as a typhoid case. The white blood count on January 5 was 3,250; red blood count, 2,360,000; hemaglobin, 41 per cent; small lymphocytes, 60 per cent; large lymphocytes, 2 per cent; polymorphonuclears, 38 per cent. On January 18 the white blood count was 12,200. Her temperature ranged from 102 to 105 degrees, and continued at this level for the first two weeks. For three weeks the average temperature ranged from 100 to 103 degrees. During these five weeks in the hospital she developed a bronchial pneumonia and she did not show any signs of improvement. On January 8 she was given the first injection of lysed vaccine, 0.5 cubic centimeter, intravenously, the second and third injections of 1.0 cubic centimeter. The temperature after each injection rose to about 106 degrees. After the third injection the temperature dropped to normal and remained normal from then on.

COMMENT

The advantages of using lysed vaccine are the following:

1. There is less denaturation of the antigen than when vaccines are heat-killed.

2. Since the killed bodies of the bacteria are removed, much larger quantities of antigen can be administered without provoking so severe a reaction as that produced by bacterial suspensions. They may be administered intravenously as well as subcutaneously.

3. Since the bacteria have been lysed, vaccine relieves the sick body as much as possible of any active reaction. During the infection the tissue cells are less responsive than during health, especially if the disease is a severe or long one. This is why an efficient serum (Passive Immunity) would be an ideal form of specific therapy.* Lysed vaccine possibly holds a position between serum therapy and ordinary vaccine treatment. In the first place, it saves the system from the strain of producing the primary antibodies for the destruction of the bacteria, since they are already lysed and endotoxins liberated. With this explanation one sees the rational basis for the employment of lysed vaccine in typhoid therapy.

The treatment of typhoid fever by means of lysed vaccine had its origin in Italy, and reports of large series of cases are found in Italian literature.[4]

It is claimed that use of vaccine shortens the course of the disease. The patients do not enter convalescence in a cachectic state. There is a sudden stimulus to the defensive mechanism, since there is leukocytosis.

Caronia [5] claims that in almost all cases the lysed vaccine prevents a fatal outcome and that its use shortens the duration of the disease.

Arcangeli believes "that the time is past when we should entrust the cure of the patient to symptomatic treatment and to the patient's own resistance."

SUMMARY

Four cases are reported in which Caronia lysed vaccine was successfully used in the treatment of typhoid fever in children.

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* Such a serum has been prepared by Dr. Gregory Schwartzmann, of Mount Sinai Hospital, New York City, by injecting horses with a toxic filtrate of B typhosus cultures along with killed organisms. A recent critical case of typhoid in a child two years of age was treated by means of this serum kindly furnished by Doctor Schwartzmann. Some 300 cc. in 500 cc. of Ringer's Solution was injected slowly intramuscularly over a period of eighteen hours. Forty-eight hours later a crisis occurred, with a drop in temperature from 106 to 97 degrees Fahrenheit. Because of shock, adrenalin was administered and eventually the child made a complete recovery.

DISCUSSION

K. F. Meyer, Ph.D. (Hooper Foundation, San Francisco).—The interesting reports of vaccine therapy in typhoid fever by Doctor Frawley enhance the already notable group of successes published by others. In fact, the communications in the possession of the discussant, covering a period of seven years, leave no doubt that the Caronia lysed vaccine has quite uniformly given good results, both in adults and children. In this respect the available records compare favorably with the early observations of Gay and Chickering (1918). Unanimously, the mildness of the reaction following the intravenous administration is mentioned. In all probability this may be attributed to the relatively small amount of toxic undenatured protein which is present in the Caronia preparation. As a mild shock reagent, this lyzed antigen has great advantages over the ordinary vaccines which may induce alarmingly severe reactions, particularly when used by the inexperienced. However, it is important to emphasize that this form of intravenous therapy is essentially a nonspecific phenomenon. Similar results have followed the administration of other bacterial preparations; indeed peptone and sera, which give rise to a protein shock, have been employed. The preferential use of the Coronia vaccine rests on the ease of preparation, control of dosage, and the experience that relapses are less likely to occur when a specific agent rather than some other protein is injected.

Gregory Shwartzman, M.D. (Mount Sinai Hospital, New York City).—Doctor Frawley's report on treatment of typhoid fever with lysed vaccines of the Caronia type, made by Dr. Karl Meyer, is of considerable interest. In the past, the treatment of typhoid fever by active immunization with B. typhosus vaccines and cell-disintegrates were shown to influence favorably the course of the disease, but had to be given up because of the dangers associated with this treatment. Thus, Ichikawa[1] reported that intravenous administration of typhoid vaccine into typhoid fever patients brought about a critical drop in temperature, and not infrequently elicited bleeding in the intestines, lungs and nose, and hemorrhage in the skin. Recently, the bleedings were interpreted in the light of the work done on the phenomenon of local tissue reactivity to bacterial filtrates.[2] In this set-up the intestinal ulcers prepared by the toxins of the typhoid bacilli may react with hemorrhage and necrosis when bacteria containing toxins are introduced into the general circulation. It is significant that no hemorrhages were observed in Doctor Frawley's series of cases. It is possible, therefore, that the toxic principles capable of eliciting the above-mentioned hemorrhagic lesions were lacking in the lysed vaccines used by him. It may be important to support this possibility by experimental evidence.

C. O. Mitchell, M.D. (Pacific Southwest Building, Fresno).—The good results obtained in the series of cases here described indicates that biological therapy in typhoid fever must be given serious consideration.

In my experience the lysed typhoid vaccine has given best results in those cases which have lasted three or four weeks, and in which progress is slow and the patient's resistance is about exhausted.

There is nothing further to be gained by symptomatic treatment, and at this juncture I have seen marked response to injections of small amounts of lysed vaccine.

The patient's immunity mechanism is stimulated in a way that seems to be too prompt and effective to be accounted for by nonspecific protein therapy.

1 Ichikawa, S.: Ztschr. Immunitätsforsch., 23:32, 1914-15.

2 Shwartzman, G.: Phenomenon of Local Tissue Reactivity and Its Immunological, Pathological and Clinical Significance. Chap. XII, p. 389. Paul B. Hoeber, Inc., 1937. Medical Book Department of Harper & Bros., New York.

PRIMARY DYSMENORRHEA*

A LOCAL MANIFESTATION OF A CONSTITUTIONAL DISEASE AND ITS TREATMENT

By MARIAN GOLDWASSER, M.D.
Los Angeles

DISCUSSION *by C. Morley Sellery, M. D., Beverly Hills; Etta Gray, M. D., Los Angeles; N. Kavinoky, M. D., Los Angeles.*

THE unsolved problem of primary dysmenorrhea is faced today not only by the gynecologist and the general practitioner to whom the numerous sufferers apply for help, but also by the school physician, who has under supervision several thousand adolescent girls from year to year. The victims of dysmenorrhea usually feel too ill to attend school, and remain in bed for one or more days every month. Those of the girls who attempt to come to school when suffering pain are too ill to attend their classes, and spend most of the day in the nurse's room.

To the school physician these girls present not only a health problem, but also an attendance problem, for their frequent absence from school causes a considerable and unnecessary financial loss to the school system—the local school board receives its allotment from the State on the basis of attendance.

Dysmenorrhea among adolescent girls occurs rather frequently. Dr. Mary Hodge made a study of 914 healthy girls in the gymnasium classes in the Public Athletic League in Baltimore, and found that 6.3 per cent required rest in bed for one day or more. In 1927, a similar study was made by Professor Miller of the College of Medicine of the University of Iowa. He found that, among 785 young college women and nurses, 17 per cent had pain sufficiently severe to require rest in bed or limited activity. Professor Miller concludes his study with the statement that the fact cannot be evaded that dysmenorrhea remains today an important economic factor.[1]

LOS ANGELES HIGH SCHOOL STUDENTS

In 1933, I made a study of 1,606 girls who had reached maturity and who were attending high school in four different localities around Los Angeles. I found that 169 of these girls, *i. e.,* 10.5 per cent, suffered from a more or less severe form of dysmenorrhea which necessitated either their absence from school or their lying down in the rest rooms for several hours during the first and sometimes the second day of the menstrual period.

The great majority of girls do not have any pelvic pathology and suffer from the primary type of dysmenorrhea, the cause of which is almost as much of a riddle today as it was thirty years ago.

GENERAL SYMPTOMS

In observing the girls who most frequently complain of dysmenorrhea, I have noticed that the majority of them suffer also from malnutrition in one form or another; that they are usually thin, anemic, and fatigued, and suffer from visceroptosis and constipation; and that many have poor posture and poor circulation, and frequently are subject to a focal infection brought about by decayed teeth, diseased tonsils, or chronic appendicitis. Many girls are emotionally unstable and restless. A smaller number are overweight, pale, and apathetic. Many have little supervision at home, keep late hours, and do not have the proper food. They take for granted the fact that they must be subject to pain and discomfort for several days every month, since their mothers and older sisters had to face the same condition in their girlhood. They expect to suffer pain at every monthly period, go to bed when it appears, and sometimes take a home remedy to relieve it, but do not suspect that their suffering is avoidable.

In evaluating all these factors in the physical and mental make-up of the girls, I began to wonder whether or not their constitutional inferiority and morbid attitude toward menstruation are only accidental, or unrelated in many instances to the occurrences of dysmenorrhea, as cause and effect; or perhaps all three are only symptoms caused by an unknown etiological factor, of which the medical profession is still in search. In order to clarify to some extent this relationship, I thought it might be worth while to make a study of a certain number of cases and see how the menstrual condition would be affected by improvement in the physical and mental status of these girls.

RECENT LITERATURE

A review of the recent literature on the subject reveals that most of the authors, after first making the statement that dysmenorrhea is only a symptom of a pathological condition, the etiology of which is so far not known in every case, present their theories and a corresponding form of treatment which proved successful in a larger or smaller number of their cases.

There is one statement, however, which can be found in practically all the latest works on dysmenorrhea, whether gland therapy,[2] insulin,[3] calcium,[4] carbohydrates,[5] control of allergy,[6] or surgery,[7] is suggested as relief, this statement is that the general health of the patient and her mental attitude should be considered as paramount in outlining the treatment.[8]

"I have always felt," says J. Novak, "that in many instances the mothers of the dysmenorrheic young girls were in greater need of sex instruction than the patients themselves; far too often the girl at puberty is coddled into the belief that the menstrual period is a time of severe invalidism." And he further adds that psychotherapy relieves a large number of patients suffering from primary dysmenorrhea.[9] Emil Novak states that "in women who are constitutionally deficient, as in the case of thin, anemic and asthenic girls, primary dysmenorrhea is very common. . . . I have repeatedly seen cases of severe dysmenorrhea improved or cured without any local treatment whatever, simply by improving the patient's general condition through measures of general hygiene."[10]

* From the Health Section of the Los Angeles Board of Education. A preliminary report of 286 cases.

Read before the convention of the Southern Section of the California State Association of Health, Physical Education, and Recreation on September 25, 1937.

Alexander Altshul suggests the treatment of dysmenorrhea with insulin, and states that, after the war, the populations of Germany and Austria suffered from lack of food, especially vitamins and mineral-bearing elements, with resultant malnutrition and concomitant endocrinopathies. The women in these countries suffered from severe dysmenorrhea, as well as from amenorrhea. The use of insulin improved the nutrition and relieved the menstrual pain on a constitutional basis.[3]

AUTHOR'S CONCLUSIONS

The suggestions of the above-mentioned authors and others, and my own observations during the nine years in which I have served as school physician, coupled with my experience in private practice, have made me feel that the treatment of the physical defects, and of the faulty mental attitude, should be undertaken as the first step, at least, in dealing with primary dysmenorrhea in adolescent girls.

TWO HEALTH PROGRAMS

With this in mind, I have drawn up the following two health programs—one to be used by the corrective physical education teacher at school, and the other to be followed by the girls at home; these programs, I felt, had to be simple, applicable on a large scale, and within reach of the needy girls who made up the majority of my patients:

I. FOR USE IN SCHOOL BY THE TEACHERS

Rest, instead of physical education.
Excuse from extra school duties.
Help the girl to receive free milk, lunch, cod-liver oil, and transportation, if the family is not able to supply them.
Corrective physical exercise after improvement has taken place.
Regular physical training not earlier than several months after the symptoms have entirely disappeared.
Psychotherapy.

II. FOR USE BY THE GIRLS AT HOME

Rest an hour after returning from school.
Go to bed not later than nine o'clock.
Take a warm bath three times a week.
Avoid strenuous exercise and dancing.
Do not walk long distances.
Drink a cup of hot water before breakfast and before supper.
Drink two cups of milk or more daily.
Eat daily a raw apple, a raw carrot, and two oranges.
Take a tablespoonful of Maltine, with iron or iodid after breakfast and after supper.
Take a tablespoonful of karo syrup in water, twice daily, one week before the expected menstrual period.

In both programs, I have emphasized the importance of rest. Contrary to the opinion of some authors, I find that most girls who have menstrual pain and are also undernourished, nervous, and overworked at home, improve better when allowed to rest rather than when compelled to exercise.

The program suggested for use at home provides, along with rest, an ample supply of vitamins, iron, fats and carbohydrates, with an extra supply of the latter prior to the menstrual period,[5] and encourages also good elimination through the skin, kidneys, and bowels. The girls who were overweight were given corrective exercises and Blaud's pills, instead of Maltine. By providing for the betterment of the general health of the girls, this program may also bring about an improvement in many endocrinopathies, hypoglycemias, and create a better resistance to allergic factors, and also a more stable nervous system.

During the past two years, between the months of January and June, I have tried out the above-outlined programs on 215 high school girls, and on eleven mentally retarded girls attending a development school. All these girls came from poor homes, and none could afford private medical care. The attendance office and the nurse referred to me those girls who had been absent from school because of menstrual pain, or, for that reason, were spending most of the day in the rest rooms. The selected pupils were assigned to special rest classes conducted by the corrective physical education teacher. Milk, Maltine, and transportation were given gratis by the schools to those who could not afford them. Every few months I questioned these girls to find out what progress they were making. The stubborn cases were referred to the clinic for more thorough examination. At the end of each semester I interviewed all the girls who were under observation and received most gratifying reports, which were confirmed by the attendance office or the nurse.

SUMMARY CONCERNING STUDENTS UNDER OBSERVATION

The compiled studies in all the schools were as follows:

BEGINNING IN JANUARY

226 girls were under observation.
141 of these girls were absent from school because of dysmenorrhea.
85 of these girls were lying down in the rest room for the same reason.

ENDING IN JUNE

171 girls had completely recovered.
32 girls had improved, having still to lie down in the rest room, but were not absent from school.
23 girls had not improved. Eighteen of these girls were in the absent group, and five were in the lying-down group.

SUMMARY OF RESULTS

75 per cent recovered; 15 per cent improved; 10 per cent not improved.

OTHER PROCEDURES

In order to carry on my experiment on a wider scale, I devoted two hours every week during the past year to the school clinic, where teachers, school physicians, and nurses from various schools referred students who were subject to dysmenorrhea, and were usually absent from school for that reason. A physical examination was made on every girl, and laboratory work was done when necessary. If decayed teeth, diseased tonsils, defective vision, or other defects were found, the girls were referred to the corresponding clinics. No pelvic examination was made on these girls at their first visit to the clinic, unless there was a definite indication for doing so.

A health program, accompanied by a talk to the patient and her mother on the possibility and importance of getting well soon, were given to every girl. If at the second visit no improvement was reported, a rectal examination was made, but pelvic pathology was seldom revealed.

In order to give courage to the girl to go to school at a time when she never before attempted to do so, Anacin tablets were given in several instances to be used at the beginning of the following period. This study in the clinic was carried on from September, 1936, to May, 1937, when a questionnaire was sent out by the clinic to some of the schools which had referred girls for treatment. The replies followed promptly. Some were supplemented by complimentary remarks from teachers and mothers. The results were as follows:

A total of sixty-seven girls were investigated, seven left school before recheck.

A total of thirty-six girls recovered, seventeen improved (were no longer absent during the menstrual period), and eight girls did not improve.

RESULTS

Sixty per cent of the girls recovered; 28 per cent improved; 12 per cent did not improve.

COMMENTS

1. From 6.3 to 17.5 per cent of adolescent girls are subject to dysmenorrhea severe enough to require rest in bed or limited activity.

2. Constitutional inferiority and a morbid mental attitude are coexisting factors in many cases.

3. A health program which provides for abundant rest, proper exercises, correct diet, and good elimination, is beneficial in these cases.

4. Some 286 girls were treated according to the above program, with the results that 72 per cent recovered, 17 per cent improved, and 11 per cent did not improve.

IN CONCLUSION

Since simple rules of wholesome living and a normal attitude toward menstruation bring about a cure or improvement in the majority of cases, the control of dysmenorrhea among adolescent girls can be achieved to a great extent by the school physician through health education. Then only the small number who fail to improve under the health program will have to be referred for further medical study.

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DISCUSSION

C. Morley Sellery, M. D. (1467 Oakhurst Drive, Beverly Hills).—Doctor Goldwasser has made a real contribution to school-health education. She has demonstrated the excellent results which can be obtained in the treatment of primary dysmenorrhea among adolescent schoolgirls by careful attention to general health measures and the education of each patient in the details of an improved personal hygiene. Doctor Goldwasser's study is a valuable reminder that much can be accomplished by adherence to the simple yet fundamental laws of health.

I am much impressed with the importance of competent medical supervision in the field of health education. Undoubtedly, the 226 girls under observation at school had received considerable health instruction through the classroom teacher and the physical education department. No doubt this teaching was of value in preparing the ground for the message of the school physician. It is important to note, however, that until the school physician outlined a definite health program and coördinated the various health facilities in the school, 141 girls out of the 226 were absent from school each month because of dysmenorrhea. As a direct result of Doctor Goldwasser's health supervision, 75 per cent of these girls recovered and 15 per cent were improved. This shows the practical results which can be obtained by health-teaching under medical direction.

Doctor Goldwasser has stressed the need for rest in the early stages of treatment for dysmenorrhea. She has quite properly urged corrective physical exercises after improvement has taken place, and regular physical training not earlier than several months after improvement. Probably this is the most difficult stage in the physical rehabilitation of these cases. The mother and daughter have believed for so long that physical exercise is harmful that it is difficult to persuade them to make the last step from semi-invalidism to normal exercise and activity. I feel that in many of these cases the permanence of cure or relief from symptoms depends on finally building up the general muscle tone of the body through big-muscle activities. With good general muscle tone, the tendency to pelvic congestion and dysmenorrhea is much lessened.

Doctor Goldwasser's study was carried on among girls from underprivileged homes. In better-class districts, similar results should be obtained by close coöperation with the family physician and the parents.

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Etta Gray, M.D. (649 South Olive Street, Los Angeles).—I am much interested in the simple health rules which Doctor Goldwasser has outlined for treatment, with her reports of a large percentage of cure.

To my mind, a great many such cases of dysmenorrhea may be treated by simple procedure of hygienic routine, and most satisfactory results are obtained.

Aside from these 60 per cent of persons so cured by simple methods, we find a certain number suffering from what can be definitely attributed to endocrine conditions. These individuals should be differentiated and studied. Certainly, marked success may be had in these cases of dysmenorrhea if they are given the adequate endocrine therapy. However, as stated by the writer, only a certain per cent of girls ailing from dysmenorrhea require more than simple therapy as outlined in this paper.

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N. Kavinoky, M.D. (1930 Wilshire Boulevard, Los Angeles).—Most thinking physicians are very conscious of the part which sexual neurosis plays in both the individual question of the health of the woman and the social question of the stability of the family. The added financial responsibility which many women are carrying today furnishes another reason for giving serious consideration to the question of dysmenorrhea.

Some of the neuroses have had their origin in the same causes which produced the dysmenorrhea, while others are in great part the result of our older methods of treatment of this condition.

In the balancing up of the diet and the development of habits of nutrition, which Doctor Goldwasser stresses in her approach to this problem, she has accomplished a great deal more than just the treatment of dysmenorrhea. The establishment of these positive health habits and attitudes

is not only a benefit to the general health of the woman, but is an important factor in the prevention of disease. Exercise, especially along the lines of the Mosher exercises, which are simply contraction of the abdominal and pelvic muscles, is a valuable therapeutic aid which can be easily learned by any girl or woman. An endocrine study of a case is of aid in making a more exact analysis of the condition, but it should come after the nutritional program has been established. Today so many women are overstimulated and are overtaxing their energies that the importance of rest cannot be too much emphasized. We need not only to allow a period for rest in the time budget, but we need to teach our women how to relax—how to rest.

The program of health education in the schools which Doctor Goldwasser has described is another step forward toward the improvement of the health of the community. Her recommendations are a valuable aid not only to the private practitioner, but especially to those of us who are interested in public-health work and in raising the level generally of woman's physical well-being.

PSYCHOPATHIC PERSONALITY: AS A HOUSEHOLD PROBLEM*

By Edward W. Twitchell, M.D.
San Francisco

Discussion *by Ross Moore, M. D., Los Angeles; Walter F. Schaller, M. D., San Francisco.*

THOSE whom we call psychopathic personalities must, of course, have been recognized for ages past, but a little more than a hundred years ago they began to attract the attention of such men as Pinel and Esquirol in France, and Prichard in England. To Prichard we owe the term "moral insanity," which is found, even today, in our literature, and in that of Germany and of France as well. Many of those once grouped under the heading "Moral Insanity" would today be called mild hypomanics, paranoids of the quieter type or occasionally early paretics. The French continued the study of these people under the names of "folie raisonante" and "dégénérés," and it must be the work of Morel and Magnan, and possibly Janet, to whom Kraepelin expresses his indebtedness, in his chapter on the Psychopathic Personalities. Morel, Magnan and, later, Koch laid much stress on the so-called stigmata of degeneration, particularly the physical stigmata. These physical stigmata were such things as facial asymmetry, abnormalities in the shape of the ear, malformations such as harelip, polydactylia and the like; then there were also tufts of white hair, cowlicks, and double crowns. One could go on at great length enumeratting such stigmata. Color blindness was a sensory stigma, and as this was known as Daltonism, those with an inherent ethical defect were known as examples of ethical Daltonism. There were even obstetrical stigmata, such as a tendency to ectopic pregnancy. These were the days of Lombroso and Max Nordau, whose work is now in large part forgotten. There was nonetheless a good deal of value in this work, and it would be wrong to ignore it completely.

KOCH'S STUDIES

In 1889, J. L. A. Koch published a short guide (Leitfaden) to Psychiatry, and in it was a chapter on the psychopathic inferiors (Minderdwerthigkeiten). This chapter was expanded, and in 1891-1893 appeared as a monograph in three sections. Most of our present work harks back to Koch, though he has now, as Kurt Schneider remarks, only an historical interest. The term currently used in all of the Government services, "constitutional psychopathic inferiority," is really but a translation of Koch's designation. For Koch almost any sort of physical peculiarity was indicative of degeneration, and one frequently finds in his histories the remark, "Flecks of pigment in the iris." This to him was highly significant. He divided all his "inferiors" into two main classes—the Permanent and the Transient—each of the two main groups being again subdivided according to severity into Psychopathic Disposition, "Belastung," and Degeneration. Kraepelin's long chapter, in the 1915 edition of his work, is today often criticized as taking a viewpoint too exclusively clinical, and the classification is objected to as purely descriptive of behavior, and Kahn makes the same criticism of Schneider, although he gives him credit for attempting to "deepen the psychological insight." Kahn's own classification, which he calls an heuristic one, may give one a better idea of the mental mechanisms involved, and one will have no great difficulty in fitting into it the grouping of Kraepelin or Schneider; still the clinical classifications are excellent working tools. As a matter of fact, classifications here, just as in other departments of psychiatry, have little worth, though they serve as a convenience in certain junctures. They are much like platforms of political parties, to be ignored when they become annoying. It is interesting to see how all-embracing some of the classifications are. In Willmann's, one may find headings for menstrual depression and for homesickness.

ENGLISH LITERATURE

When one considers how numerous these patients are and the long while they have been generally recognized, it is remarkable how little has been written in English. In Schneider's Bibliography of 304 items, dated 1922, the only article in English mentioned is Beard on Neurasthenia, and Kahn, though translated into English and published at Yale in 1931, does not cite one. Allowing for the German tendency to ignore everything done outside of Germany, worse, of course, since the war, this means that relatively little has been done in English.

Take up any of the textbooks of the day, English or American, and you will find the whole subject compressed into a few pages, sometimes into a few paragraphs. There are plenty of journal articles on this or that aspect of the question, but a systematic presentation in English has yet to appear.

THE PSYCHOPATHIC PERSONALITY IN YOUTH

The psychopathic personality is ubiquitous, but the handling of him, in his youth at least, devolves upon three agencies—the home, the school, and the courts. Many make a sort of orderly progress from home to school and thence to the court, the court either sending them back to home or school, or on

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.

to prison or psychopathic hospital. The problem I have set myself today is a consideration of those at home and school, and up to the time they are taken over by the court. Long before they come into court they are brought to us by anxious parents. The state institutions are constantly being appealed to by parents and guardians who want help in dealing with their problems.

What at first may seem a trifling defect in character, treated maybe with amused smiles, later gets to be deadly serious. The child who pilfers from the mother's purse, for example, later robs the grocer in the neighborhood, and before long is in the penitentiary. The small boy who makes such advances upon his nurse that she is afraid to stay alone in the room with him later becomes the terror of all of the mothers in the neighborhood.

SEXUALLY PRECOCIOUS TYPES

Warden Johnston of Alcatraz, in a recent address, said that our prisons were permanent exhibits of our failure to solve the problems of childhood. Hence, if we are to do much for these people we must start when they are very young. We cannot, as Dr. O. W. Holmes advised, begin one hundred years before they are born, but we may, if we will, begin soon after birth. Several types are brought to us over and over again; the sexually precocious, for example. It is astonishing how this type may be overlooked by the parent. One girl of twenty-five, sexually promiscuous since her menstruation at thirteen, on her own admission, was brought in by her mother, who was just beginning to be suspicious. The real reason for the consultation was the girl's misophobia; she would take a dozen baths a day if permitted. The blood Wassermann was strongly positive. Three years later the girl was in jail as a prostitute and sent to a farm for erring women, which was once maintained by the State in Sonoma. There she was a model inmate. Two years later she was reported doing well. Ten years later, still she was reported as married and living a good life—one of the occasional happy endings and not so uncommon as usually thought, as prostitution is merely an episode in the life of many a woman whose later life is quite regular. The sexual perverts do not do so well. A fetichist, when fully developed, tends to continue as such, even though he make an adjustment in marriage with a normal woman. One fetichist, who seems to have been conditioned in childhood in an orphanage, by a servant with a lame leg, whose kindness to him he ever remembered, used to roam the streets at night after his work in the orchestra was done, looking for a girl with a short leg, before he went home to his wife and family. Another, who in childhood got sexual excitement by opening and inspecting packages, still gets into trouble by opening and inspecting the contents of packages which he never keeps. Unfortunately, some of the packages are on the top of mail boxes.

INVERTS

The same is true of the inverts; one under observation for years, who but a year ago declared that he had overcome his tendency, recently went out with a sailor who robbed him, after beating him so that he spent a month in the hospital. I am skeptic when I hear of the cure of inverts. It is like changing the leopard's spots—they can, however, manage a certain control; and so live that they are not a scandal to family and friends and keep out of the clutches of the law and the blackmailer.

PERVERTS

The life of the perverts is often a secret known to but few, and their perversions may never bring them into conflict with the law; furthermore, many perversions are accepted nowadays as but trivial variations from the normal. The sadist, of course, may do things of violence which lead him to the police. They injure their victims in such a way that they are often brought to the notice of the police, particularly when the victim is a child or a prostitute who meets them in a business way. Wives are less fortunate. One sadist recently seen would impulsively attempt to thrust his entire fist up his wife's vagina. She had learned to barricade herself in her room on perceiving a certain expression come over his face.

PRESTIGE HUNGRY AND HYSTERICAL TYPES

One group is a source of great trouble to families, and that is the liar and swindler, to use Kraepelin's designation, which Schneider classes as prestige hungry (Geltungsbedürftige), and Kahn as the hysterical. They start very young. They lie to avoid trouble, but more often to put themselves in a more shining light. They steal in order to get what will enhance them in the eyes of their playmates at first, and later of their mistresses.

It would be hard to exaggerate their excesses. One mother told me of a son costing her $75,000 in two years, the greater part of her fortune; another son had brought his father to complete financial ruin.

HOUSEHOLD OR FAMILY PROBLEM TYPES

These types—the sexually precocious, the inverts, and the liars and swindlers—impress me as being household or family problems, problems that cause the greatest anxiety. There is the occasional irascible whose quarrelsome nature makes him impossible at home or in school, and who may find himself in the juvenile court before long, but is not the source of anguish that the others mentioned are; his violent temper may bring him to commit assault, or even homicide, but a homicide in the family tree is better than an invert. The cold autist, who becomes an enemy to society and may do the most cold-blooded things, usually drifts away from the family early and may pass out of their ken completely.

There are certain others, the weak-willed, the unstable, the inadequate, and the like, who are thorns in the side of ambitious parents who built high hopes upon them, and are chagrined to see the son for whom they have planned a great career turn into an amiable, third-rate organist. I generally try to console such parents by telling them that, while a well-behaved nonentity may be no source of pride to a family, at least in comparison with

a genius who is also a scandalously living homosexual, he is to be preferred. Geniuses are by no means an unmixed blessing, and a genius must be hard to live with, even the best of them.

Where drunkenness is not a chief manifestation of a psychopathic personality, as it sometimes is, it is often an associated one, and one that complicates a case that otherwise might be manageable. The gentle sot, like Rip Van Winkle, is often a village favorite, though little joy to his family; but the swindler, who is a sot to boot, is a double infliction.

THE EGO CHARACTERISTIC

A never-failing characteristic of all these people was seized upon by Koch in his early work, *i. e.*, "das ungebührlich in den Mittelpunkt gerucktes Ich"—the ego shamelessly put in the foreground. They are all selfish, and all without feeling for the sufferings of others. With tears running down his face, the boy who is saved from jail by the sacrifice of his mother's home, swears he will never do it again, yet repeats the act in a week. They are often, strangely enough, indifferent as to their own future penalties. A woman, released on parole from San Quentin where she had been sent for "paper hanging," hardly stepped off the ferryboat in San Francisco when she wrote another check. A lawyer borrowed money on the strength of a deed of property to himself; on the deed he had forged the name of a banker who was a personal acquaintance of those from whom he was borrowing.

CONCEIT ELEMENT

Conceit is another characteristic. The prestige-thirsty individual is conceited as well. One of the strangest manifestations is the superior feeling of the homosexuals, who tell you blandly that they are a superior type of creation. Not often does one see an invert who is self-depreciative, though I remember one who, on discovering what he was, wept and talked of suicide.

Taken as a general rule, then, we are dealing with those who are selfish, conceited, and unfeeling, with an intelligence that ranges from low-normal to genius. The physical characteristics, about which one could say so much, especially since the work of Kretschmer, I pass over deliberately as not pertinent to the present discussion.

Most of these people are hereditarily tainted, and while I do not underestimate environment, one so often sees such cases as L. A., a son of street-fair performers, abandoned in his infancy and adopted by well-to-do people, who provided what would be regarded as the best of care and education. In his grammar and high-school years he turns out to be a problem by reason of general untrustworthiness.

TREATMENT

What can we do to avoid the charge that our neglect fills our penitentiaries? My belief is that training is just as good for children as it is for dogs and horses. No good horse or dog trainer is brutal to his animals, but he sees to it that they are disciplined without indulgence. We need not go back to Spartan methods; anyway, the Spartans left no monuments and are known only from what others wrote of them. But a certain amount of rule is necessary. Long before Solomon said, "Spare the rod and spoil the child," an Egyptian cut on stone the following aphorism, "A boy's ears are on his back; he hearkens best when beaten." We have been living in a period of tendermindedness. Someone I seem to remember calls it "This ghastly thin-blooded time of ours," or words to that effect. Vegetarianism and antivivisectionism are products of our time. There is too much Society for the Prevention of Cruelty to Animals sentiment abroad. The hungry pioneer, working his way over the passes of the Sierra, did not hesitate to shoot because the soft eyes of the deer filled him with compassion. He thought of the wife and children who had had nothing to eat since the day before. The normal boy on a holiday wants to go out and kill something. When he grows older, grows fat and short-winded, he begins to be sorry for the deer and the dove and the duck. The older brother of a young man who had progressed through a series of embezzlements in public office, all of which had been made good by the family, said, when the young man was sent to prison for robbing a bank, "Maybe if we had let him take the rap the first time he would not be where he is." Drastic punishment for each offense would, I am sure, lessen the offenses. I have often felt that those whose habit it is to obtain money on false pretenses, whether by check, by borrowing, by running up bills and the like, would hesitate if they knew the offense would be followed by corporal punishment. They stand the sufferings of others with great fortitude, but not their own. The problem is how to accomplish this under the law. The long-suffering brother of an offender who went across the country in a stolen car, leaving a trail of bad checks behind him, said, when I broached the matter, that he thought that by reason of his connection with the district attorney's office, he could arrange the punishment in an extralegal way.

It would be well if some way could be found to deal with these individuals who seem not so much to be increasing in numbers, as growing bolder and more cynical in their behavior. If we do not, we shall quicken our national degeneration. At the present we may be on the path of the Byzantines, and eventually we may go down overwhelmed by some future Turks. Let us stay the process in what way we can.

Some of these patients need our protection; we may persuade the ambitious parents of a good-natured, well-behaved inadequate to cease driving him on to a goal which he never can attain, and let him make his way in a subordinate rôle. The parents need treatment more than the son. We may point out to the inverts the nature of their trouble, the value of control, if control be possible, and particularly the hazards of their future life. The homosexual, especially if well-to-do, is a prey for all sorts of predatory persons, and if he be warned in advance may be able to escape their traps. The homosexuals may be told that he and she may lead an orderly life in spite of the infliction with which they are burdened, for the homosexual may live a life without scandal as the heterosexual may lead

a life of debauch. There are many inverts who have kept themselves under control and lived respected in their communities. This is particularly true with women. The worst thing about these unfortunates is that when they begin to indulge their desires to any degree they are apt to be dragged down to the level of their companions.

The antisocials I am leaving out of account, as they cease to be household problems pretty early and find their way into the courts and thence to prison. They are like the cold autists above mentioned, and the irascibles, who in their rages commit deeds of such violence that they are immediately brought under control of the police.

It is particularly for the lying and swindling group that I wish to urge a stern discipline from very early years. For them the present-day tendency to let them express themselves without let or hindrance is to put a premium on their giving free rein to their selfishness and conceit. This means, of course, a complete change in the present-day system of dealing with the young. As the present method of letting them do as they please is a reaction from the stern and sometimes brutal treatment of a hundred years ago, so must there be a gradual stiffening of discipline, with an intelligence greater than shown in the past. This will come about, not only because it will be seen as the wise thing to do, but because the situation will eventually get so bad that self-preservation of society will dictate the method.

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DISCUSSION

Ross Moore, M. D. (1930 Wilshire Boulevard, Los Angeles).—In approaching the problem of the psychopath in the home, I find myself constantly trying to evaluate him on the basis of his relative adequacy or inadequacy to life.

There are some psychopaths who can be helped to lift themselves out of the problem class. In other words, there are persons who are perfectly able to live on the psychic level of their present surroundings, provided they become relieved of certain removable handicaps.

The program of treatment for such psychopaths is clear and not complicated. It usually requires neither long and repeated psychoanalytic seances nor sanitarium regimen. Just a common-sense inquiry into discoverable causes and a rigorous elimination of the same.

The other group of psychopaths includes those pathetic personalities who are essentially or biologically inadequate for life in the sphere or on the psychic level wherein their lots are cast. They are the unfortunate ones. For neither they themselves nor their relatives are willing to admit their permanent handicaps. Thus their successful treatment has far higher hurdles to jump. Both themselves and their friends have to be forced to accept, as bitter fact, a situation they have trained themselves to strenuously deny. Frequently this acceptance cannot be forced. Thus, the poor patient shuttlecocks about among doctors and sanitaria, grasping ever vainly at a will-o'-the-wisp promise of health.

Nevertheless, such persons can, in a good proportion of cases, be helped if effort be persisted in long enough. Such therapeutic success is the result of entire honesty of attitude on the part of the doctor, which ultimately reflects itself in an honest acceptance of himself by the patient. Success of this kind is well worth the effort.

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Walter F. Schaller, M. D. (909 Hyde Street, San Francisco).—The psychopathic personality is most often an expression of a psychopathic constitutional state, by definition an inherent psychobiological defectiveness. These individuals from birth are poorly endowed to meet the demands of ordinary life situations from the standpoint of social, moral, and emotional standards. To the layman these deviations represent but conduct disorders; to the psychiatrist they represent inborn defects, characterized by strong impulses, weak wills, superficial emotions, and irresponsibility. The true nature of the disorder, as Doctor Twitchell points out, is often overlooked in the home and the school, and not discovered until brought to light by a social behavior which calls the patients to the attention of the psychiatrist or, more frequently, of the law. These cases are often classified as constitutional inferiors. As a rule, they are not mentally deficient, and cannot be definitely classified among the psychoses. They are, therefore, on the borderline of the mentally capable and incapable. The severer cases are not benefited by any known therapeutic approach, as is possible, for example, in the psychoneurotic reaction types, from which they must be clearly distingunshed.

In the milder types, I agree with Doctor Twitchell in the importance of early diagnosis and an attempt to strengthen the will and cultivate inhibition by deterrent methods. We are now living in an era aptly described by Aring and Bateman (*Journal of the American Medical Association,* October 2, 1937), as one characterized by a national neurosis. Unemployment and relief, the loosening of home and church ties, and the laxity of the law in minor offenses, to which may be added the popular educational idea of self-expression, cannot but further demoralize a psychopathic personality.

IONIZATION IN ALLERGIC RHINITIS*

By H. J. Hara, M.D.
Los Angeles

Discussion *by G. W. Walker, M. D., Fresno; Edward C. Donohoe, M. D., Glendale; Benton N. Colver, M. D., Glendale.*

NASAL zinc ionization concerns itself with the introduction of zinc ions into the superficial layer of the nasal mucous membrane by means of the galvanic current.

INSTRUMENTS

The instruments used in ionization are (1) a generator for galvanic current, (2) conducting wires for positive and negative poles, (3 electrolytic solution or suspension in jelly, and (4) electrodes. The galvanic current is obtained either from (1) wet- or dry-cell batteries, or (2) motor generator from house current. When the free ends of the two poles or electrodes are connected, the current flows from the positive pole to the negative pole. When a solution of zinc sulphate is employed as the conductive media, zinc molecules are dissociated from the sulphate radical, the zinc ions going to the positive pole. Zinc sulphate in the strength of one-half to two per cent is used as the electrolytic solution. Warwick's [1] "Ionode" contains 85 per cent zinc, 10 per cent tin, and 5 per cent cadmium. His electrode contains these metals in the same proportion. Cottle [2] recommends 2 per cent zinc, with 5 per cent tragacanth suspended in jelly. Earlier in my experience I used only Warwick's solution and a fresh electrode in each side of the nose. Later, one-half per cent zinc sulphate solution was substituted and more recently Cottle's jelly.

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PREPARATION AND OPERATIVE TECHNIQUE

The presence of polyps and a deflected nasal septum interfere with the proper contact of the electrolytes with the nasal mucosa. Correction of such nasal pathology is made four to six weeks prior to ionization. When acute sinusitis coexists, ionization is deferred until the acute stage is over. In seasonal rhinitis, best results are obtained after the onset of hay fever. The adult receives the usual preoperative sedatives by mouth and hypodermic. Cocain and adrenalin are used for local anesthesia in the nose. Children require general anesthesia. Either one or both sides of the nose are treated at one sitting. Hurd [3] and others flood the nasal chambers during the operation, while the head is kept in the dependent position. Warwick originally insisted on packing the nasal cavities with several strips of half-inch fiber cotton, well moistened with his trimetal solution, and then placed the electrode between them. The instillation of zinc jelly greatly reduces trauma. I prefer to have the patient lying down with the head resting on a pillow. The dispersive pole, with the well-saturated felt pad, is fastened to the upper arm or back of the neck. An insulated wire, which leads from the positive pole of the generator, is attached to the electrode in the nose. The current is then turned on gradually and the treatment continued until 100 to 150 milliamperes are given to each side (10 milliamperes for ten to fifteen minutes).

At the conclusion of the treatment the nasal mucosa presents a thin, grayish coagulum on the surface to which it is firmly attached. In three to five days this coagulum is cast off, and the mucous membrane appears smooth and salmon-colored.

HISTOLOGIC TISSUE STUDY

Histologic examination of the cast shows a vast number of leukocytes enmeshed in desquamated epithelium and fibrin. During the next three months there occurs an infiltration, chiefly of monocytes and lymphocytes, with a generalized increase in the density of the tunica propria. The mucous glands atrophy, goblet cells disappear, and eosinophiles persist. The picture is that of true fibrosis. The surface epithelium remains cuboidal for months. According to Smit,[4] these cells eventually regenerate into ciliated columnar type when no chronic inflammatory process is present. A specimen removed from the middle turbinate of one of my patients two years after ionization revealed complete regeneration of the normal ciliated cells.

ANALYSIS OF ONE HUNDRED CASES

My experience in the treatment of allergic rhinitis by the use of ionization began in the fall of 1934. Sixty of the one hundred cases herein reported were treated during 1935, and forty during the first half of 1936. There were thirty-six cases of hay fever, seven of which were complicated with bronchial asthma. Among sixty-four cases of chronic vasomotor rhinitis, thirteen patients suffered from bronchial asthma. There were fifty-four males and forty-six females. Thirty-seven had nasal surgery done prior to being seen by me. Three were five years of age and one was sixty-five years old, the majority being in the third and fourth decades. All came because of unsatisfactory results from previous treatments. Twelve patients were given a second treatment after the lapse of from four weeks to fourteen months. Three of these received no benefit from either the first or second treatment. One gardener with hay fever took three treatments, but the results were far from satisfactory. One patient with vasomotor rhinitis, complicated by bronchial asthma, took three treatments at intervals of six months. His nasal condition improved, but he suffered recurrent attacks of bronchial asthma. Following each ionization, he was relieved of the asthma for a period of from four to six months. Ionization apparently produced no change in other cases which were complicated with bronchial asthma. Four patients complained of anosmia, three of whom regained their sense of smell in from four to twelve weeks following treatment. The fourth, a physician, still has impaired olfactory sensation five months after his second ionization.

Follow-up reports, after ten to thirty months, showed failure to give any relief in about 20 per cent of hay fever cases and 14 per cent of vasomotor rhinitis. One ionization controlled 50 to 60 per cent of hay fever, and 66 per cent of vasomotor rhinitis cases; but in the course of time it appeared that the shrinking effects produced on the nasal tissue gradually disappeared, and it returned to its previously waterlogged, boggy, inelastic condition; the nose being more or less wet.

To study the comparative efficiency of the various modalities now in vogue in the control of allergic rhinitis, a small number of patients were selected. The first group was treated by cauterization of both lower and middle turbinates with 50 per cent solution of trichloracetic acid. The entire nasal mucosa of the patients in the second group was coated with pure phenol. In the third group the nasal mucosa was painted with 50 per cent solution of silver nitrate, and the fourth group had the turbinates and nasal septum injected with 50 per cent alcohol. No other treatment was given to these groups. They have been under observation from twelve to twenty-four months. Time does not permit a detailed report on each series, but none of the above methods has given as lasting palliation as has ionization.

INDICATIONS AND LIMITATIONS

It should be remembered that ionization does not alter the allergic state of the individual. The Alexanders [5] have shown that when active reagents are present in the blood of hay fever patients, ionization yields no relief. This is to be expected. Another drawback is the possibility of permanent injury to the nasal mucosa, but Alden [6] thinks that the relief obtained more than compensates for the tissue damage. Dean [7] states that ionization is helpful in patients with a maximum of chronic vasomotor rhinitis and a minimum of allergy. He is of the opinion that it is not necessary for the control of hay fever. This is probably true in St. Louis, where a large number of hay fever patients suffer from ragweed pollen during six to eight weeks in

the autumn. In the semitropical State of California, pollinization occurs nearly throughout the entire year. Multiple sensitivity is the rule rather than the exception. The majority of seasonal cases sooner or later become perennial. Thus, the problem presents decidedly different and difficult aspects.

In the light of present knowledge the sane and sensible approach to the management of all cases of allergic rhinitis is first to break the contact with the active allergen and next to desensitize. In actual practice, however, this may be impossible. It is necessary, therefore, that an appropriate nonspecific treatment be tried. Dietetic errors must be corrected, endocrine imbalance regulated, and every focus of infection eradicated. In addition, the nasal chambers must be kept as near the normal state as possible. Some time in the course of their ailment nearly all allergic rhinitis patients seek the services of one or more rhinologists. The allergist, endocrinologist, internist, roentgenologist, dietitian, and others, may be called in as consultants whenever their services are deemed necessary in the best interest of the patient, but the rhinologist must carry the full responsibility for the adequate management of these cases. One who depends on only a single modality for the relief of all the symptoms present in such a complex disorder as allergic rhinitis, is almost certain to be disappointed. Ionization is no exception to this rule. It is no more than a therapeutic adjunct.

SUMMARY

It may be stated, in summarizing, that the result of ionization for hay fever patients over a period of from ten to thirty months was good in from 50 to 60 per cent of patients, failed in 20 per cent, and over the same period a single ionization controlled 66 per cent of chronic vasomotor rhinitis patients, moderately helpful in 20 per cent, and failed in 14 per cent when no other treatment was given.

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DISCUSSION

G. W. Walker, M. D. (533 T. W. Patterson Building, Fresno).—This subject has been well written and much discussed previously. Possibly there has been overenthusiasm in the work of some who presented the subject, but far greater errors have been made, in my opinion, in the criticisms expressed by opponents who have condemned the whole procedure—I think without sufficiently careful investigation—but I think others speak more from prejudice or from seeing nasal ionization poorly done.

Doctor Hara has ably presented the case of intranasal ionization for hay fever—I do not say case for ionization—but he has presented it just as the facts warrant, giving both sides—and there are two sides.

I think there is a tendency by some to accept a new method with undue enthusiasm, and that others are unduly critical, each without sufficient knowledge of the new method in question. Probably all of those who are too easily won as friends will too easily drop the method as useless when they encounter some difficult situations. If there were not an enormous number of sufferers who, like Doctor Hara's patients, had been treated with very little benefit by other methods, and had suffered so badly—as they do suffer here in the West by unrelieved hay fever—there might be little or no place for ionization. They suffer too much in the six hours following ionization to lightly consider it as a remedy; but the pain can be pretty well taken care of by sedatives. Their nasal breathing being completely shut off for the next four days is objectionable. Their slightly crusty nose for two weeks is another objection. Cases need to be very carefully selected. If I had only a little trouble from hay fever, I would not have ionization; but if I suffered as many of these patients do, I certainly would have it done. Those who object that the nose is permanently damaged from ionization are, I think, mistaken. I have watched these noses for about four years with as much follow-up as I think one can hope to do. I am intensely interested in the follow-up. So far as I can see about the macroscopic appearance of the nasal mucosa after two or three months following ionization, there is no appearance of any destructive result.

One candid and able critic has expressed fear that atrophic rhinitis might result from intranasal ionization. That would be a serious result, so I have very carefully examined about one hundred cases I have treated, dating back to three or four years ago, yet failed to find any evidence of any undue shrinking of tissue such as occurs in atrophic rhinitis.

I note that Doctor Hara has used one-half of one per cent zinc sulphate in some of his cases, and jelly more recently. I have always used the two per cent solution, with the exception of just a few cases where I tried jelly. It seemed to me that I did not get the jelly applied to all parts as I should, and I went back to the solution-saturated cotton.

I have not tried Doctor Hurd's method. It may be a good one. I have had some failures, but I have had such encouraging percentage of cases that did well that I still speak for intranasal ionization. I think there is ample place for its use. Some tell us that the same results can be expected from application of phenol, trichloracetic acid, strong solution of silver nitrate and other topical application. I do not believe they can be compared in result with ionization. Some think it might succeed in vasomotor rhinitis, but not be helpful in proved allergic cases—that is, oculonasal pollenosis. I have gotten my best results in definite allergic rhinitis.

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Edward C. Donohoe, M. D. (229 North Central Avenue, Glendale).—Beginning the use of ionization long after Doctor Hara's early investigation, it was our understanding that the zinc ions penetrated deeply into the tissues, bringing about a foreign body reaction with resultant fibrosis. Because of this, we have used quite weak current for shorter periods than usually employed, hoping to cause less interference with the vascular supply and minimize any consequent atrophy.

When anesthesia is employed we make use of pontocain, but in some cases no anesthesia is used. We shrink the tissues with ephedrin, and then endeavor to fill the nasal fossa with a zinc containing jelly. Only one fossa is ionized at any one time. The electrode is placed on the forearm.

Ionization is used by us only in elderly individuals with anosmia and considerable polypoid tissue in the nose. These people are usually given some relief, often for a short time only. The brief duration in some cases may be due to the moderate dosage which then often does not exceed fifteen milliamperes. Treatments are repeated as symptoms recur.

It has been a question with us as to whether the relief experienced would excuse the use of an agent which de-

stroys the glands and might permanently impair the function of the nasal mucosa. It is not unlikely that the relief our patients receive is due to the same factors which apparently bring about temporary relief following acute infections or after trauma to the nose.

We believe, with Doctor Hara, that ionization is merely a therapeutic adjunct and that its use should be very limited.

Benton N. Colver, M. D. (1650 Melwood Drive, Glendale).—Doctor Hara has quite fairly stated the problem of handling cases which are clinically diagnosed as allergic rhinitis. Primarily, the patient must be taken into consideration as a whole, and have necessary consultation and care as may be indicated by his individual findings. Secondly, the ideal approach is to ascertain the allergens which are effective in his case. When this determination is made, steps should be taken to desensitize specifically. The impossibility of successfully carrying out this step in every case compels the rhinologist to seek some other form of help for a considerable number of his patients.

Finally, these cases, where failure to really solve the problem has resulted in continuance of the annoying symptoms, compel the rhinologist to resort to "symptomatic relief." Among the means employed is zinc ionization. This modality is admittedly a last resort after specific therapy has failed. So far as the patient is concerned, anything which will give him relief of his symptoms is acceptable. The use of the ionization does not preclude further study along the more desirable line of specific therapy.

Zinc ionization has been decried because of the suspension of certain normal functions of the nose. Experience and patience have revealed, however, that functional activity is not permanently lost. It might be compared to a massive dose of deep x-ray therapy which causes depilation and suspension of secretory function of glands in the neighborhood. Both of these effects are undesirable, but are not permanent, so that in due time hair growth is resumed and normal secretion begins. I believe that this is true of ionization in the nose so that any unpleasant symptoms can be tolerated in exchange for a relief from the annoyance of the allergic symptoms.

I feel that the careful selection of cases and accurate technique of ionization merits a continued "trial" and a careful tabulation of results in sizeable series of cases by a good number of dependable observers and clinicians.

INFECTIONS IN THE DANGER AREA OF THE LIPS, FACE AND NOSE*

By G. W. Walker, M.D.
AND
Hugh Awtrey, M.D.
Fresno

Discussion *by Harry Wiley, M. D., Huntington Park; Rea E. Ashley, M. D., San Francisco; Charles William Brown, M. D., San Diego.*

IN this article we do not expect to go deeply into the question of pathology, for it is well covered in the literature by Fraser,[1] Koslin,[2] Ayers [4] et al., Totten,[3] and numerous other authors.

NATURE OF A FURUNCLE

Briefly, a furuncle is confined to the hair follicle and immediately near-by tissue. If not traumatized, it usually stays so confined. If traumatized, and possibly at times without it, it may extend to the adipose tissue and escape all confines near to the hair follicle, erode veins, only slightly deeper, and spread along horizontal connective tissue layers in all directions, little unhampered by any successful attempt at protective walling off; and in places it may come to the surface along vertical structures, causing multiple openings, when the process is termed a carbuncle.

The skin in this region is thin, in intimate relation with underlying muscles, and the veins are valveless and communicate freely through the angular vein with the superior ophthalmic, and through the inferior ophthalmic and pterygoid plexus with the cavernous sinus. The process may erode veins, or thrombi may form, thus pouring the infection into the blood stream, and may extend to the meninges. The fact that the system has ordinarily no protective immunity against the Staphylococcus aureus, and little time to prepare it, admits of disastrous results with overwhelming rapidity.

At the last meeting of the Academy of Ophthalmology and Otolaryngology in New York, Batson had an exhibit which demonstrated the futility of trying to interfere with the condition by ligation of the communicating veins with the deeper ones, there being such an extensive and irregular anastomosis that, except with major surgery, inadvisable at the time, the process could not be cut off and thereby confined, even if one could know they were early enough.

Infections in this region occur much more frequently after puberty, as the hair follicles and sebaceous glands are much more developed after this period, though some have occurred at an earlier age. It seems to occur more frequently in the male than in the female, and on the lips and cheek.

THERAPY, AS REPORTED IN THE LITERATURE

Advice in the literature as to treatment runs all the way from strictly leaving the pus there, and using flaxseed poultices, through the use of vaccines, x-rays, heat, cautious incision, to the extreme radical of crucial incision, or radical exsection of the affected area.

Many suggest no surgery be done, and Dittrich [5] says that surgically treated cases have produced about twice as great fatality as nonsurgical. Probably more grave cases have been operated than minor ones because of desperation, etc., and that might partly account for the greater mortality. But there are fatal cases reported when conservative nonsurgical treatment was used, though no trauma had been inflicted.

Surgeons usually advise where pus is found, evacuate it. One, condemning sole reliance on poultices, although he was considering abscess in another area, but would apply here, too, remarked that "the doctor might often have to depend on the abscess to rupture three days after death." The crucial incision of wide and deep extent produces a horrible cosmetic result. The incision that goes wider and deeper than it should invites disaster by completing the way for fatal extension. Where pus is found, evacuate it, but the incision should be confined to making simply an adequate opening to evacuate it, and only deep enough to do so. Such incisions are compatible with a perfect cosmetic end-result, with best safety and the shortest possible recovery period when combined with the proper application of pure phenol, melted crystals, and no

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

dilution; not even with the popular addition of 5 per cent water, which admittedly makes the drug more convenient to use, as then it is liquid at ordinary temperatures.

METHOD OF USING PHENOL

One writer, Koch,[6] says, "The sooner we forget the notion that phenol and other drugs are helpful the better," but we are strongly persuaded to believe that such a statement concerning phenol emanates from a lack of experience with the proper use of it. Before this Society, in 1914, one of us (G. W. W.) read a paper on certain uses of pure phenol, and in the discussion I was surprised that some of the leaders of our profession failed to grasp that I was talking about the use of pure phenol, and spoke of experiences with the use of various dilutions. I was talking about pure phenol. If they had not spoken of dilutions less than 95 per cent, I might have paid little critical attention to their discussion, but they seemed to think of dilution anywhere down to 5 per cent, and dressings being bound on the skin saturated with various dilutions, while I was talking of application of pure phenol as mentioned above, followed in two minutes by alcohol to stop its action. Consequently, we believe that even good surgeons might sometimes fail to grasp the proper method of using phenol. However, two authors do make favorable mention of the use of pure phenol, one of the best descriptions of its use being by Totten.[3]

Sometimes there is destruction of the epidermis over the area of the carbuncle, with minute fistulae opening from the deeper area. If the integrity of the superficial structures of the skin is not good, remove it and paint the area with pure phenol, following in two minutes by washing off with alcohol to stop the action of the phenol. After the diseased cutaneous surface has been removed, in cases where it is already abraded somewhat, one will usually find sinuses, sometimes minute, which can be followed with a metal applicator on which is tightly twisted absorbent cotton; applying the cotton in one continuous wrapping on the wetted applicator so that it will stay on better, the cotton being twisted along the applicator to a greater length than the depth of the cavity. If the sinus size is ample, or is made so by judicious incision, make the pledget bigger. We should not cut through the infected into healthy area in deeper tissue, but in any event follow by phenol. If no sinus can be found, open with a narrow-bladed knife to the subcutaneous area of destruction and follow with phenol. When one wishes the opening larger, cautiously widen the incision, all the time keeping near the center of the diseased mass and promptly applying phenol wherever the incision goes. The multiple openings of carbuncles must be found and followed to their limits, without trauma deeper than the pyogenic process has gone. With the phenol applicator, one can usually break down septa and connective tissue and open a carbuncle into fewer, or into one cavity.

Cases do not become grave if properly treated before the carbuncle stage.

We have followed this out in six carbuncle cases: three in the cheek near the nose; one in the cheek, spreading from the side of the nose; and two in the upper lip and cheek, as well as in many less grave cases.

In those which have become grave, search for the center of the infected area and make application of phenol to areas a few millimeters apart. If no pus cavity is present, the carbuncle development stops.

Of course, if a pus cavity originating in a hair follicle preceded, at least that one pus center is discoverable, and pathologic processes therefrom can be attacked, not by one continuous line of incision or excision, but if careful search finds no other pus yet formed, frequent narrow incisions, of only proper depth should be made. These to be spaced only about four millimeters apart, each well phenolized. Such frequently placed incisions and gentle insinuation with cotton-wound applicator and phenol will often break into pus cavities, and from these leads lateral extensions can be found and followed to destination.

Watchful waiting allows the possibility of intracranial involvement. Careful incision and phenol, such as outlined here, arrests the process.

There is some sting from the application of the phenol, but that sting stops in about six seconds and the area becomes anesthetic. Local anesthetics should not be used for obvious reasons. The phenol anesthetizes. Manipulation done as gently as it must be, will not hurt from then on. After the application of phenol on the surface, the area needs to be covered and protected from outside temperature for about two hours, for there will be some burning sensation for about that time that is greater if exposed to room temperature. Drains should be inserted as needed to keep sinuses open, and careful and frequent cleansing to keep crusts from sealing openings until débris separates and allows healing.

Many mention the good from vaccines or x-rays and emphasize that they must be begun early. Sometimes you do not encounter the case early, but whatever the stage of the local focus, phenol stops it at once, if properly applied, and you do not have to delay a day or two for improvement.

Totten says "clinical results are not to be measured by only recovery or fatality, but also by results of treatment shown in twenty-four to forty-eight hours from beginning it, and to know the severity and presence of complications." That is certainly correct. He advises hot boric or magnesium sulphate solution applications until pus forms.

COMMENT

This is not something that we have used simply for two or three cases over a period of a few months and about which we have become greatly enthusiastic only to drop all after a season. One of us (G. W. W.) has used this in such manner since A. M. Phelps's description of its use in 1898. Phelps stated that it had been applied for years by Seneca D. Powell in the Postgraduate Hospital of New York. Phelps was a frequent writer on the

subject of joint affections. He advised the use of pure phenol, followed in two minutes by alcohol in abscesses in joints; also in erysipelas, painting it liberally on the skin over the area affected. Then, in general practice I so used it, painting it over an area of erysipelatous inflammation of the skin, and for about three inches beyond the area apparently affected. I learned that if I had a large area to be painted, that I must paint patches no greater than from three to four inches square, or less in case of an infant, neutralizing with alcohol after two minutes before proceeding further; that is, not to paint a large area of the body at one time before neutralizing, or there would probably be shock from an overdose of phenol.

I recall using it in a case of extensive metastatic abscesses involving one hip joint, one shoulder joint, and back over the whole of the scapula, one elbow and wrist joint, with a large sinus communicating in the interosseous space between the ulna and radius, from the elbow to the wrist, in which case I cut into all of the joints and diseased cavities, using pure phenol throughout all of them. The patient, though violently sick, promptly got well, the temperature falling at once. Perfect function of all parts resulted, except some tendency of one hand to contract, requiring mobilization for a time.

So I have used this in abscesses from whatever organism, and carried this over from my general surgery experiences and through my otolaryngology, and have never seen it fail to stop the process when the pyogenic process was followed throughout. In one case of erysipelas with phlegmon and pus burrowing throughout the length of the upper and lower eyelids, which were enormously thickened by the process, there was a common opening at the inner end of each lid, also at the outer end of each; thence the sinus extended to the ramus of the lower jaw, where it was opened and down subcutaneously to below the clavicle. Through four openings in the skin, cotton pledgets were passed on hemostats throughout the whole subcutaneous abscesses. Also, the patient had cutaneous erysipelas over both sides of the face, neck, and most of his head. This patient, an attorney, though then violently sick, was promptly made well, and there is almost no mark today to show where he was treated.

Of course, erysipelas and other suppurations than in the title are not under discussion primarily in this paper, but instead staphylococcus infection. This diversion was only to say more about application of phenol.

Of course, too, if the patient is moribund from cavernous sinus thrombosis and meningitis and we stop the original focus, he still may die from the cavernous sinus affection and meningitis although the primary focus be blotted out. Some patients have recovered from cavernous sinus thrombosis, so the original focus should be blotted out as soon as found, if possible, for either prevention of extension or to relieve the load. We are confident no other treatment will blot it out so promptly as the proper application of pure phenol throughout the area where pus is forming.

Do not hesitate to open to the pus, for the incision is promptly sterilized by the phenol. Do not carry the surgical trauma beyond affected area. We have used this in all cases, both mild and severe, with uniform good results, and so far have not had the misfortune to deal with a case of infection in this danger area in which we have come in charge of the case so late as to find sinus thrombosis and meningitis already developed, but following this method will prevent extension. Such a treatment, followed since Phelps's writing in the late nineties, bears that out in our experience.

To be sure, these cases are grave from early in the carbuncle stage, and the patient should be treated accordingly as to bed confinement, etc. The simple furuncle may require little or no treatment, although phenol properly applied will greatly hasten its complete recovery; but no trauma of its environment is safe.

IN CONCLUSION

We have only briefly reviewed the pathology. There are many articles in the literature, parts of which are good, some more nearly all the way through than others. Some advice we think bad. Evacute pus. Make incisions only wide and deep enough, no more. Apply pure phenol to all incisions, find all pus cavities, and phenolize. Incise and phenolize at near-placed intervals in infected area, if big. It will not necrose and cause bad cosmetic result. It stops the pathologic process. Interlying tissue not already necrotic will live and preserve form. It saves life. It is compatible with speediest recovery.

532 T. W. Patterson Building.

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DISCUSSION

Harry Wiley, M.D. (2701 Florence Avenue, Huntington Park).—To me the title of this paper is somewhat ambiguous and not wholly germane to the subject matter. When I first read it I expected a discussion of that time-honored subject of infections of the face and nose, particularly above the lip line. While this subject has been written about and discussed freely for years, I cannot believe there has ever been enough said about it. I am sure that each one of us has at some time in his life seen a simple little "pimple" on or near the nose develop into a raging infection that resulted in death. Since the author is not discussing this particular phase of infections, I can only say in passing that I would emphasize that injunction to the patient, which should be repeated over and over to everyone having this disturbance, "Do not squeeze."

It seems to be the intention of the author to bring out and emphasize the use of phenol in pustular infections, particularly those of streptococcic origin. He has covered the ground so thoroughly and well that there is little left for me to do except to commend his paper. Most of us remember that before the days of vaccines, S. T. 37, mercresin, mercurochrome, and a host of other dyes and germ-killing applications, phenol and bichlorid of mercury were

practically the only two things used for this purpose. Phenol was the *sine qua non*. It did the work just as the author has described it would, and it will still do it if you will use it as he tells us to—that is, in its pure and undiluted form. When used in its pure state it precipitates the albumins in the tissues and prevents its own absorption, but when diluted in any degree whatever there is more or less absorption, danger of poison and of local gangrene around the parts where it is applied. I do not agree with the author in the necessity of neutralizing with alcohol unless the phenol is used to excess and invades some of the surrounding healthy tissue. Although no harm is done if the alcohol is used, it is not necessary, as the phenol will only penetrate a certain distance in any event.

Again, I want to commend the author for once more bringing to our attention this worth while drug which has somewhat fallen into disuse in recent years.

❦

Rea E. Ashley, M. D. (384 Post Street, San Francisco).—Several years ago I had the pleasure of hearing Doctor Walker discuss the phenol treatment of furunculosis of the external auditory canal. The treatment which he outlined at that time was similar to the one which he now presents for the treatment of infections about the face.

Since that time I have had several opportunities to test the antiseptic properties of pure phenol in infections about the ears, nose, and throat. The results have been so uniformly good that for several years I have also used pure phenol following incision of peritonsillar and retropharyngeal abscesses.

The advantages of phenol, as I see them, are:

1. It is highly antiseptic.

2. It is readily neutralized by alcohol, and thus its action can be accurately controlled.

3. It has escharotic properties which prevent the sealing of the abscess after incision, thus providing free drainage.

In my experience no bad results have been encountered in the phenol method of treatment as described by Doctor Walker. It deserves wider use in infections about the face.

❦

Charles William Brown, M. D. (Bank of America Building, San Diego).—Doctor Walker has adequately described the nature of a furuncle, and this should be deeply impressed upon the laity as well as the doctors. Too many are inclined to squeeze and thus bruise the tissues external to the natural protective wall that the body attempts to form for localizing the infection.

The adolescent is one in particular that does so much of this damage, and rightly so, for youth desires rapidly to do away with such a face blemish, when in reality the worst thing that could be done has happened in this bruising of the protective wall, thereby allowing the infection to spread rapidly, especially if it comes in contact with one of the larger veins.

I have many cases to show the damage done in not properly treating the "boils" or infections above the line marked by the angle of the mouth.

The infections in the hair follicles in the nasal vestibule are very trying to many, and I wish to state that many of these furuncles are due to allergic disturbances. In the past year I treated a woman who would have these pimples in the vestibule each time she ate lettuce.

Just last year a boy, sixteen years of age, squeezed a pimple near his nose and lip and it cleared up with treatment, but he developed shortly a perinephritic abscess that necessitated opening and prompt recovery ensued. This case was in the San Diego County General Hospital.

Doctor Walker has given a thorough outline of the treatment of infections of the face, and I am in hearty accord with his method of treatment:

1. Diagnose.

2. Liberate pus, if present, by incision; do not traumatize by pressure, but clean by swab or applicator.

3. Phenol applied as directed. I do not wait two minutes, as Doctor Walker states. The reason is probably fear. When area is deep gray in color, apply pure alcohol and leave in pack or applicator for two or three minutes.

4. Apply loose dressings and give general supportive treatment.

5. In suspected streptococcic infection, sulfanilamid in form of prontolyn or prontosil. Dosage depends on size of the patient and severity of the disease. This is but recently an added treatment, but one I think we should not overlook in giving our patients every opportunity for speedy recovery.

It has been my pleasure to treat many erysipelas and erysipeloid cases of nose and ear, as well as small abscesses, furuncles, fissures; and even the frequent and simple fever blisters respond readily to phenol and alcohol treatment.

In closing, may I urge that this paper be read not only by ear, nose and throat specialists but by men in general practice, who will benefit by using such treatment in general use.

HANDWRITING A NEUROLOGICAL STUDY*

By H. Douglas Eaton, M.D.
Los Angeles

Discussion *by Samuel D. Ingham, M. D., Los Angeles; Walter F. Schaller, M. D., San Francisco; Joseph Catton, M. D., San Francisco.*

IN 1622, Baldo, an Italian professor of philosophy, stated: "The study of an intimate letter discloses the thoughts, the moods, and the dispositions of the writer."[1] Notwithstanding this early observation, handwriting has been a subject little studied from the medical standpoint. Handwriting disorders, present in many neurological diseases, and often valuable diagnostic aids, receive but slight mention in foreign neurological literature and still less in our own. This neglect is due to a number of factors. The value of such a study in diagnosis is often only confirmatory—the clinical diagnostic picture may be present before or at least coincident with the handwriting changes. Furthermore, the determination of deviations from normal is made extremely difficult because of the lack of normal standards. Speed of writing production may be measured accurately and a comparison made with normal averages. Style and legibility, on the other hand, do not lend themselves readily to estimation and comparison, save perhaps from a medico-legal standpoint, as in determining a forgery.

In graphology, or the study of handwriting, departures from the normal may occur in form or content; we may have, as Joffrey suggests, calligraphic or psychographic disorders.

Disorders of the content of handwriting, psychographic disorders, are of interest solely from the psychiatric standpoint and do not come within the scope of this paper. I may mention, in passing, that the written productions of a psychotic patient frequently give sufficient information to make possible a diagnosis of the type as well as the presence of a psychosis. Some years ago, in a study of 1,500 letters, comprising the so-called "Nut File" of the Los Angeles Police Department,[2] this was clearly demonstrated. Automatic writings may yield much subconscious material of value in a psychoanalysis of their author.[3]

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

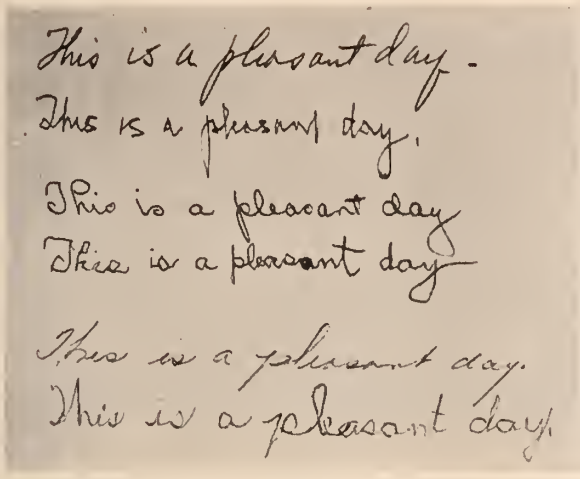


Fig. 1

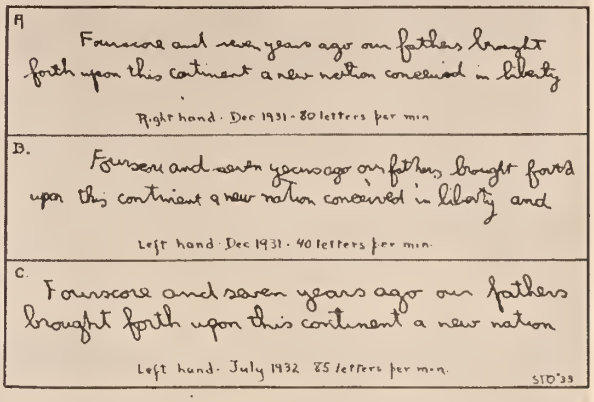


Fig. 2

Fig. 1.—Comparison of right and left-handed writings in dominately right-handed individuals. Illustrates variations in slant, form, speed, and resemblances.

Fig. 2.—(A) Left-handed dominance in all activities forced to write right-handed from age 11 to age 17. Stutterer. (B) Left-handed writing without training. (C) Left-handed writing after six months' training, speed greater than right. Taken from Orton.[4]

HANDWRITING DISORDERS IN NEUROLOGICAL CONDITIONS

The purpose of this paper is to present and discuss some of the recognized types of handwriting disorders found in neurological conditions.

The acquirement and production of normal handwriting is obviously dependent on (1) an intact central nervous system and (2) correct training of an organically sound central nervous system. As normal writing results from the interaction of a visual, a kinesthetic, and an auditory record—disorders in any or all of these or in their interrelationships may presumably result in handwriting disorders. The acquirement of visual records may be interfered with through gross refractive errors. There may be marked individual variations in muscle sense, both in health and disease. Sound association disturbances probably occur, but have not been proved as yet to be of primary importance.

CHILDHOOD TYPES

In childhood, delays in learning to write, or handwriting disorders, may be due to lack of cerebral or cord tissue and to toxemias, inflammations, traumas, lacerations, or hemorrhages affecting the central nervous system. Here lack of or actual destruction of nerve tissue results in absolute or partial inability to write. In such conditions associated evidence of other motor dysfunction is usually present, as in the spastics and dystonias. This is a fairly obvious group. Mild types must be borne in mind and ruled out before making the diagnosis of a purely functional disorder.

Another type occurring in childhood is called congenital apraxia. These children with normal intelligence, without definitely demonstrable motor or sensory lesions, and without evidence of organic pathology, yet show difficulty in learning all motor patterns which require a high degree of complexity of muscular movements. They show fair skill in the simpler, phylogenetically older, movements such as walking, running, or grasping, yet are poor in sewing, dancing, or tennis. In this group, writing sometimes remains a difficult problem throughout life.

Incorrect training of an essentially sound nervous system usually arises from errors in the use and development of the dominant hemisphere as indicated by the work of Orton and others.[4] Children forced to use the right hand in writing when

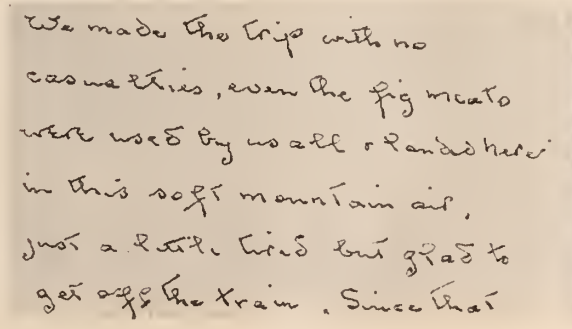


Fig. 3

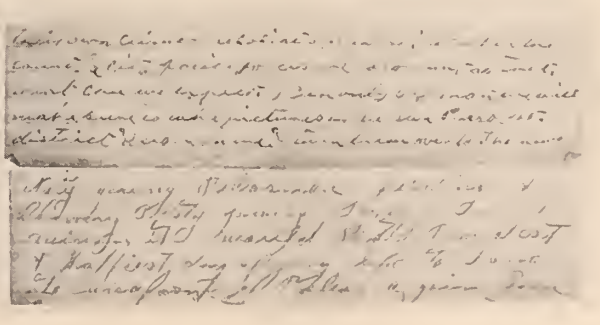


Fig. 4

Fig. 3.—Illustrating tremor, waviness, and slight cramping. Male, age 61. Cardiovascular changes without hypertension. One cardiac accident, no cerebral; fundi arteriosclerotic.

Fig. 4.—Illustrating tremor, waviness, cramping, illegibility. Male, age 75. Senile changes without demonstrable pathology. Male, age 76. Senile psychosis without focal lesions.

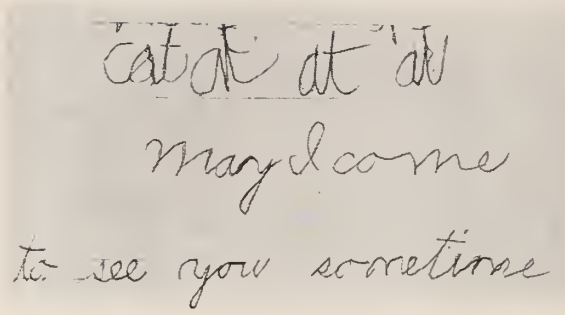


Fig. 5

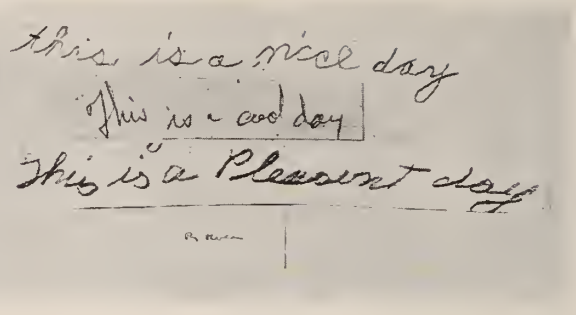


Fig. 6

Fig. 5.—Illustrating tremor, faulty alignment, illegibility. Female, age 8. First line after one year public school.

Fig. 6.—(A) Illustrating waviness, faulty alignment, lack capital. Female, age 12. Little's disease with conduct abnormalities. (B) Cramping, faulty alignment. Male, age 32. Encephalitis lethargic, chronic type. (C) Tremor—cramping, faulty alignment. Male, age 18. Little's disease, psychoneurosis. Can only write while standing. (D) Micrographia. Normal individual.

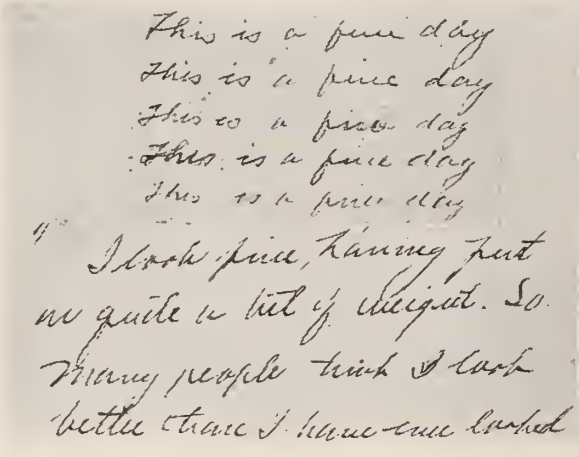


Fig. 7

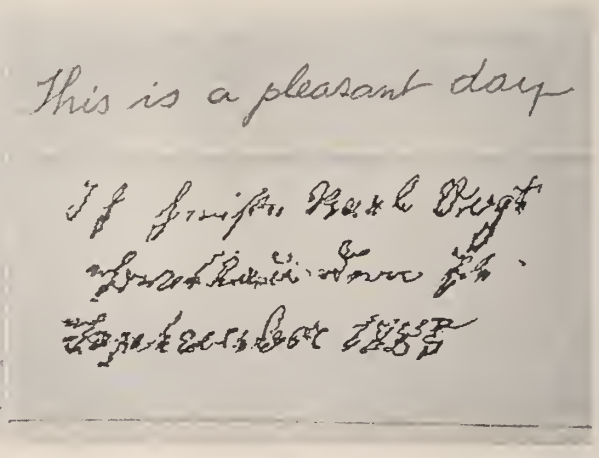


Fig. 8

Fig. 7.—(A) Illustrating difficulty in starting, dropped letters, and increasing cramping on sustained effort. (B) Normal handwriting eight years later. Female, age 30. Encephalitis lethargica. Parkinsonian syndrome, infection at age 23. Positive neurological findings.

Fig. 8.—(A) Illustrating tremor, micrographic tendency, increasing cramping and faulty alignment with fatigue. Male, age 51. Paralysis agitans onset at age 48. No antecedent infection. (B) Male, age 56. Paralysis agitans onset at age 50. No antecedent infection.

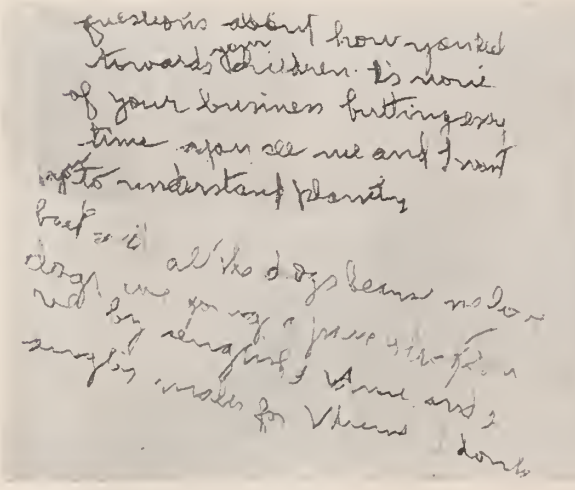


Fig. 9

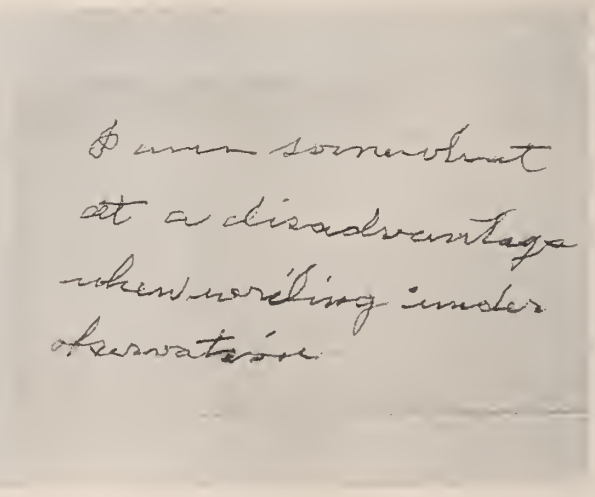


Fig. 10

Fig. 9.—Illustrating cramping, faulty letter formation, repetition of words, omission of letters and words, faulty alignment. Increased deterioration eighteen months later. Female, age 41. Huntington's chorea with dementia, maternal inheritance with alcoholism and mental instability. Coronary death at age 46.

Fig. 10.—Illustrating uncertainty, tremor, cramping, faulty alignment, faulty letter formation. Male, age 54. Multiple sclerosis. Onset at age 39. Progressive with remissions.

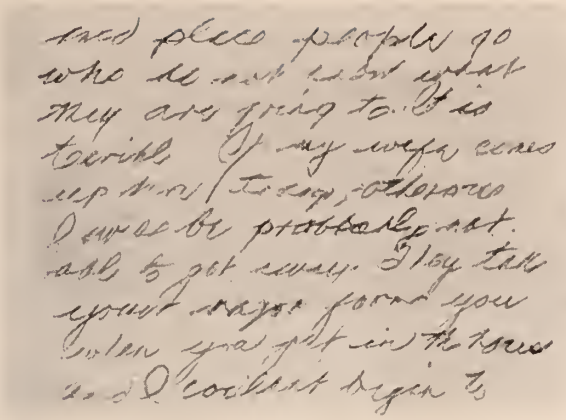


Fig. 11

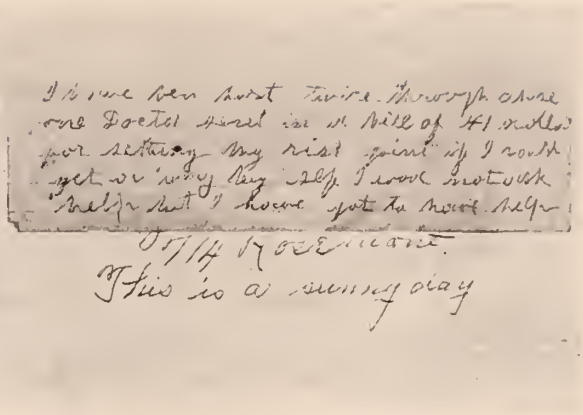


Fig. 12

Fig. 11.—Illustrating slight tremor, cramping, faulty alignment, omission of letters and words, illegibility. Male, age 52. Paresis. Chancre at age 33. Malaria previously. Scattered treatment, no check for fifteen years. Typical serology. Duration mental symptoms two months.

Fig. 12.—Illustrating tremor, cramping, omission of letters and words, faulty alignment, illegilibity. Male, age 58. Chancre at age 30. Typical serology. Duration mental symptoms six months. Female, age 43. Chancre questionable. Typical serology. Duration of mental symptoms, four months.

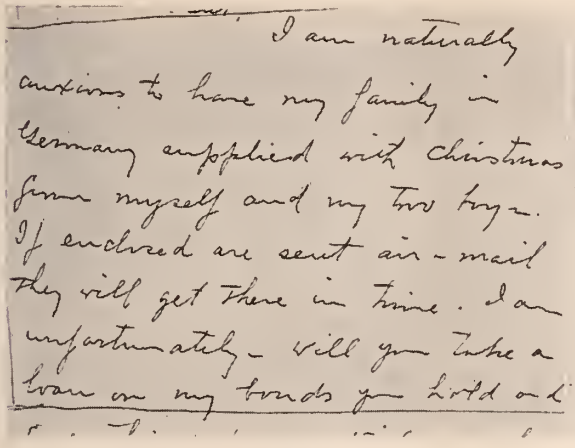


Fig. 13

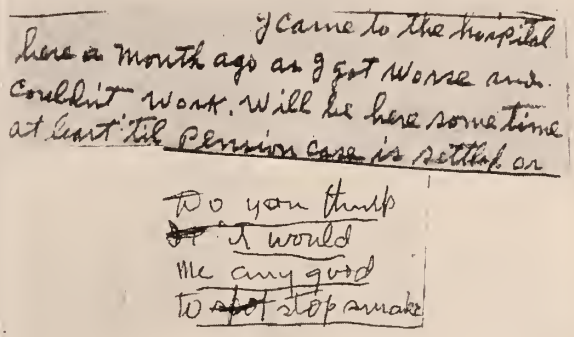


Fig. 14

Fig. 13.—Illustrating slight tremor, faulty letter formation, faulty alignment, omission of letters and words. Male, age 43. Chancre at age 28. Typical serology. Continuous treatment including malaria.

Fig. 14.—(A) Illustrating waviness, tremor, faulty alignment. Male, age 41. Alcoholism with peripheral neuritis. (B) Uncertainty, cramping, faulty letter formation, omission of letters and words, faulty alignment. Male, age 56. Progressive muscular atrophy with bulbar symptoms. Onset at age 46.

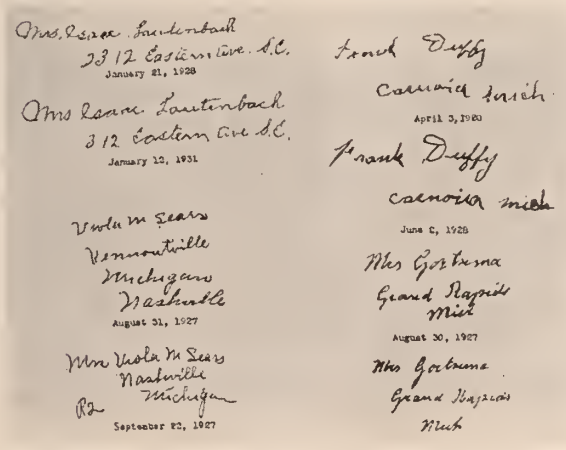


Fig. 15

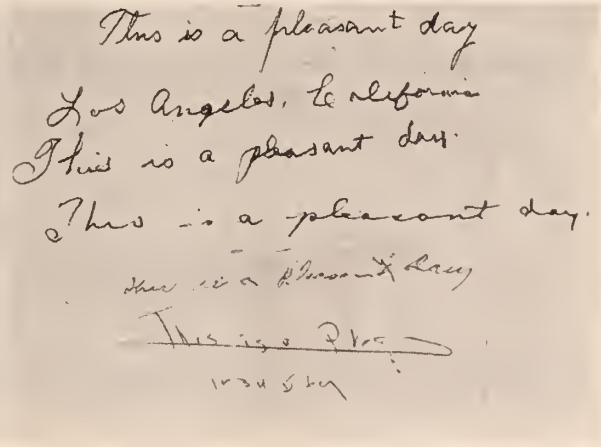


Fig. 16

Fig. 15.—Illustrating tremor, cramping, faulty alignment, illegibility. Toxic goiters pre- and postoperative. Taken from Berg.[5]

Fig. 16.—(A) Illustrating tremor, slight cramping, faulty alignment. Male, age 55. Writers' cramp, onset at age 53. Pullman conductor, both hands involved. (B) Tremor, cramping, faulty alignment, micrographic tendency. Male, age 48. Writers' cramp. Onset at age 31. Lawyer, one hand involved. (C) Tremor, cramping, micrographia, illegibility. Male, age 46. Writers' cramp. Onset at age 36. Auditor. Both hands involved.

dominately left-handed, or allowed to use the left in writing but forced to use it in right-handed positions, frequently show persistent slowness and disability in writing. Such writing disability may also be associated with definite developmental disorders. Children taught to write with the right hand, but allowed to use the left for all other activities, may show writing disorders due to lack of clear-cut hemisphere dominance. In this group are also found reading and spelling disabilities, cases of so-called strephosymbolia. The early recognition of these cases is important to permit early special training; to guard against their being classed as mentally defective and to prevent the development of psychoneuroses. Some years ago I examined such a patient, now in college, whose history discloses repeated psychoneurotic episodes occurring during the period of his life when, though dominately left-handed, he was being forced to write right-handed. Correction of this error, together with proper training, eliminated the psychoneurotic episodes and resulted in markedly improved academic standing.

This group of early functional handwriting disorders which I have just discussed are found much more commonly in males than in females—approximately in the ratio of six to one. Evidence of similar writing disabilities is found in the family histories of these cases, and it is, therefore, believed that there is a sex-influenced hereditary factor present.

HANDWRITING DISORDERS IN ADULTS

In adults the types of handwriting disorders just discussed are relatively unimportant, and the disorders caused by acquired diseases are of more interest. As in childhood, diseases resulting in organic central nervous system changes are of prime importance. Cerebral hemorrhage, associated with cardiovascular disease, or trauma, involving motor areas and pathways, results in varying degrees of handwriting disturbances, from slight tremor with wavy up-and-down strokes and cramping to complete agraphia. Without gross or demonstrable lesions we see the tremulous cramped writing of the senile.

Tremor and uncertainty are present in encephalitis. Multiple sclerosis is said by one author to be characterized by "wild scrawls." In my own experience, either no definite changes or tremor and uncertainty, as found in encephalitis, is more common. Paralysis agitans shows typically a micrographia and tremor, which grows progressively worse in proportion to the length of the production. Paresis has received more attention from the handwriting standpoint than any other neurological condition, probably because the changes in this disease are so easily demonstrated. The omitted letters or words, with the extreme tremor and illegibility, are readily recognized.

The various toxemias often make themselves apparent in the written word. The handwriting disturbance caused by excessive indulgence in alcohol is familiar to us all, at least in others. Some years ago Berg called attention to the tremor of toxic goiter and its improvement postoperatively.[5] In the group of toxemias we find disturbances in the finer movements, carelessness in form, tremor; and in the severer alcoholic toxemias especially, omission of words or sentences, needless repetition, and increasing illegibility.

WRITING DISORDERS OF FUNCTIONAL ORIGIN

The classical example of writing disorder of functional origin is to be found in so-called writer's cramp—here we see demonstrated in the early stages an extremely cramped micrographia; in the latter stages an illegible scrawl.

The one case of Huntington's chorea studied resembles the production of a paretic with marked tremor, illegibility, omitted words and letters, and extremely faulty aligment.

In summary, the study of handwriting disorders in childhood often result in the recognition of organic or developmental disturbances of definite educational value. A similar study of adult productions may be of definite diagnostic value. Further study is warranted.

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DISCUSSION

Samuel D. Ingham, M. D. (727 West Seventh Street, Los Angeles).—The material presented by Doctor Eaton is very interesting and suggests a field of diagnosis that has not been sufficiently developed in the neurological direction, although certain handwriting experts have studied the subject extensively.

In connection with the applications which Doctor Eaton has suggested, the variations in handwriting which occur with organic nervous diseases might be considered in relation to the location of the pathology in the nervous system. Thus, lesions of the spinal cord causing weakness or incoördination of movement in the hands, lesions in the cerebellum causing dysmetria, lesions of the mid-brain causing intention tremors, lesions in the diencephalon causing nonintention tremors, and lesions in the cerebral cortex causing different types of paragraphia, each give a different and characteristic change in the handwriting from that which is normal to the individual.

Study of a large number of cases, and an analysis of the different abnormalities in writing, would no doubt be of aid in neurological diagnosis and localization.

Walter F. Schaller, M. D. (909 Hyde Street, San Francisco).—Doctor Eaton has given us, in a concise manner, the pathological aspect of handwriting, which is quite as important in clinical diagnosis as other signs of abnormal motor behavior, such as gaits, attitudes, disturbance of associated movements, and uncontrolled motor acts. Excluding cases of mental defectiveness, lack of training

in writing, carelessness, those due to brain lesions or other structural changes, there remains a definite group of specific handwriting difficulties, frequently unrecognized as such in school children. This may exist in rare cases as an isolated defect, but is more frequently found in developmental alexia, the strephosymbolia (or twisted symbols) of Orton, in which spelling and writing are likewise affected, to even a greater degree than reading, because recognition is easier than recall. A sample of handwriting, therefore, may lead to the diagnosis of developmental alexia. The writing of these children is fairly characteristic in the reversals of words and letters, especially the letters *d* and *b*, *p* and *q*. They frequently show other evidences of mirror reading and writing. Children with this hindrance find it exceedingly difficult or impossible to learn to read by the flash-card method, as opposed to the phonetic system; instruction in the latter method often aids greatly in their ability to read as well as to write. Individuals who are dominantly left-handed should not be forced to write right-handed, and when left-handedness exists as a biological deviation in the nature of a regressive character, especially when accompanied by other such signs, the handicap imposed on these children by switching, even when they are not markedly left-handed, is such that they cannot readily adapt, and they may develop psychoneurotic reactions, including stuttering.

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Joseph Catton, M.D. (490 Post Street, San Francisco). Neurological, psychological, and psychiatric studies of handwriting will always be important. I share Doctor Eaton's chagrin that so little authoritative work has been reported in the literature, both here and abroad. Doctor Eaton's paper concerns itself with those aspects of handwriting where one's feet may be kept on the ground; it deals with factual, solid stuff. I hope he may continue his researches into more dangerous fields, for I am one who believes there are important findings to be made where gross neurological disorder is not present.

Without "the will to believe" (I hope) I have recently submitted six specimens of handwriting to a so-called "graphologist." She holds an important position in the American Institute of Grapho-Analysis. All identification data were deleted from the letters sent. Here are my estimates of her analyses, compared with full medical and psychological records in my possession.

Specimen	Analysis Per Cent
A killer in death row at San Quentin	20
A radio personality; alcoholic, unadjusted	95
A woman, homosexual, artist, taking drugs to alleviate distress of larynx carcinoma	85
A dramatic editor of a newspaper, three days before committing suicide	70
A paranoid praecox, killer, residing in State Hospital	80
A member of the California Medical Association Council	90

Average estimate, 73 per cent.

This "analyst" has for years read handwriting for the National Board of Fire Underwriters; their general manager wrote her during March, 1938: "Received analyses, and we find them, as usual, 100 per cent correct." I report this only to suggest that before final "yes" or "no" may be given to the value of "graphology," it would be well to take a thousand specimens of norms, psychotics, neurotics, etc. Eliminate all identification data; have competent persons take clinical records to which numbers have been assigned, and make cold comparisons with "analysts" reports, and . . .

Back to earth! Content of manuscript, time, and lineage factors are important and must be understood. Quinan (I have seen his blind approach to final analysis of data) picked out the executives, small department heads, and men in lower positions on police force and in industry by time and lineage readings of the test written sentence, "He protested that he couldn't eat the twenty-two tarts; and the truth is that he ate twenty." Quinan, again, found that the crossed types (one eye dominant and the heterolateral hand being used for writing) were present in much higher percentages in speeders, reckless drivers, dementia praecox, constitutional psychopathy, artists, musicians, and preachers.

THE NUTRITIONAL PROBLEM IN TOXEMIAS OF CONTAGIOUS DISEASES*

By Milton Tobias, M.D.
Los Angeles

Discussion *by John C. Ruddock, M. D., Los Angeles; Albert G. Bower, M. D., Hollywood; George M. Stevens, M. D., Los Angeles.*

In toxemias, accompanying contagious diseases, the dietary regimen is too often a casual addendum to a carefully planned treatment. Fluids are forced; glucose is introduced parenterally in conjunction with a high carbohydrate, a maintenance or low protein, and an abundant vitamin intake. We challenge the competency of such generalities; in their stead, we suggest the physiological determination of metabolic needs and of gastro-intestinal misbehavior.

In disease, as in health, nutrition is correct and its balance is positive when all requirements for maintenance and growth are fulfilled. These requirements are established by the unique physical, chemical, and energy phenomena peculiar to the current metabolic situation. Conditioned by an increased metabolic rate, by an increased catabolic activity (cellular wear and tear), the previously positive becomes a negative metabolic balance. To paraphrase, "The metabolic balance is in the red." The toxic patient must have correspondingly abnormal and augmented nutritional demands. These increased demands, ordinarily, are satisfied by reserve depots whose sufficiency makes autogenous convalescence possible.

NUCLEOPROTEINS AND PHOSPHOLIPIDS

From the manifold ramifications of the nutritional problem in toxemias, the inclusion of abundant nucleoproteins and phospholipids was selected for clinical study. Insulin administration was included in our procedure.

A schematic discussion of both cell and liver will make our hypothesis more intelligible. The vital structure of every cell is a colloidal system in which nucleoproteins and phospholipids participate.[1-4] The source of energy for cellular activity is primarily the utilization of glycogen; and the control of cellular behavior is affected by the interchange of substances with its immediate environment. There occurs, in nice equilibrium, a constant flux of electrolytes, hormones, enzymes, and nutritional elements to and from the cell. The introduction of any toxic irritant into this extracellular medium, disturbs protoplasmic chemistry; interferes with the precise mechanism of cellular function; provokes cellular sacrifice; and, commensurately, destroys nucleoproteins and phospholipids.[5,6] Since the nucleoprotein and phospholipid content of normal tissue is fairly constant,[7] their increased destruction should necessitate a compensatorily increased intake, replacement sufficient to convert their negative into a positive balance.[9]

The liver, like all body tissues, is probably profoundly and unfavorably influenced by a severe

* Read before the General Medicine Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

toxemia.[13] Its normal complex activities, consequently, are altered. Such impaired function disturbs its metabolic responsibility in isolating unsaturated fatty acids from the blood stream; in synthesizing phospholipids and supplying them to the body tissues at need;[8] in regulating glycogen metabolism;[13] in preparing amino-acids and other nutritional elements for subsequent utilization in the body tissues.

During a toxemia the increased tissue requirement for phospholipids and nucleoproteins constitutes a correspondingly increased demand upon this already dysfunctioning liver.[9] It is relevant that the most constant postmortem finding in toxemias is fatty infiltration of the liver. Such fatty infiltration suggests a causative alteration in the function of liver cells related, possibly, to a deficiency in lecithin (a phospholipid), or in cholin (an amin incorporated in lecithin).[14]

A strikingly similar fatty liver was described by Hershey and Soskins in depancreatized dogs that died with symptoms of liver failure.[10] By lecithin feeding, one dog remained alive two and one-half years, to die later of a terminal illness unrelated to any failure of liver function.[11] The addition of lecithin to the diet of these diabetic animals alleviated frequent critical episodes characterized by signs of liver failure. Fatty infiltration in the liver was produced, also, by the feeding of small quantities of cholesterol, and was prevented by the addition of cholin[12] (an amin incorporated in lecithin). This experimental data suggests that phospholipid intake may play a considerable rôle in preventing an abnormal deposition of neutral fat in the liver; a fatty infiltration analogous to that seen in toxemias.

From the preceding discussion we may imply—to be adequate—nutrition for the toxic patient must provide an ample phospholipid and nucleoprotein intake.

Time and text prevent the discussion of additional factors such as ferments, vitamins, activators, and catalysts.

CLINICAL MATERIAL OF THE STUDY

Nucleoproteins, phospholipids, and insulin administration were, for the first time, deliberately included in the nutrition of a toxemia in the case of V. P., age twenty months, admitted into the California Hospital on January 1, 1930, and discharged on January 19 of the same year. The diagnosis was severe acrodynia. Despite the application of every then known therapeutic measure, her clinical career included progressively increasing anorexia, muscular hypotonicity, cold beefy hands, loose teeth, repeated eruptions and conjunctivitis. On admission, her condition was critical, semi-comatose, and gavage was necessary. The diet prescribed contained liver 50 grams, brain 15 grams, two egg yolks, and represented 5 grams of lecithin; four units of insulin were administered three times daily. On her seventh hospital day, she ate voluntarily, sat erect, attempted to walk, and stopped pulling out her hair. The patient was discharged on her eighteenth hospital day, happy, walking, and eating without coercion.

Unusually toxic children were chosen as subjects for our investigation. Included in this series were septic scarlet fever with complications, bull-neck diphtheria, universal erysipelas during infancy, septicemia, sepsis of undetermined origin, nephrosis, pertussis pneumonia in infancy, and severe typhoid fever. In aggregate, according to our experience, such entities have an approximate mortality rate of 30 per cent.

Since 1931 one hundred such patients have received a soft high carbohydrate, high vitamin diet, rich in nucleoproteins and phospholipids. In this group rather dramatic clinical improvement was not uncommon, but the most consistent response to our procedure was the one most difficult to record—the intangible factor, a beneficent change in clinical personality. Regardless of etiology or complications, however, such nutritional tactics were at no time injurious. Our mortality rate was 8 per cent.

Three case reports have been selected from the above series to describe the illness treated, the dietary regimen instituted, and the clinical response obtained.

REPORT OF CASES

Case 1.—D. B., seven years old, admitted on July 15, 1935; discharged on July 30, 1935. Diagnosis: Nephrosis.

The patient, on admission, had an edema involving the lower abdomen and extremities, and a brownish area of discoloration extending from the right labia majora to the right thigh. Her blood pressure was 95/70; temperature was 103 degrees. Many fine granular and hyaline casts; two plus albumin and many pus cells were found in the urine. Blood chemistry was the following: NPN 27, cholesterol 222, NaCl 495, serum albumin 1.5, serum globulin 2.1. The edema spread over the face and entire body. On July 18, 100 grams of liver, 6 egg yolks, 5 cubic centimeters of bioplastina intramuscularly, and 5 units of insulin three times daily, were included in her regimen. Two days later, on July 20, her fluid intake was 350 cubic centimeters and the output 850 cubic centimeters. The patient's blood chemistry on the following day was: NPN 27, NaCl 412, cholesterol 278, serum albumin 2.4, serum globulin 2.3. An uneventful recovery ensued, and she was discharged as cured on July 20, 1935.

* * *

Case 2.—E. C., five months old, admitted on March 29, 1935; discharged on April 14, 1935. Diagnosis: Erysipelas.

On admission, after twelve days' illness, the patient was extremely toxic, had a temperature of 105 degrees, neck was rigid, and the erysipelas extended from the back of the neck over both shoulders anteriorly to the clavicle. Despite continuous cold magnesium sulphate compresses, antitoxin, and daily introduction of intramuscular blood, the erysipelas, now edematous and vesicular, descended below the navel to the buttocks, and included the upper extremities and the entire back. The patient's temperature varied between 104 and 105 degrees, and her condition was critical. On April 7, 1935, we added 60 grams of liver, 6 egg yolks, 5 cubic centimeters of bioplastina, and 5 units of insuin three times daily to her regimen. Two days later her temperature was normal and the erysipelas subsequently rapidly disappeared. She was discharged as cured on April 14, 1935.

* * *

Case 3.—D. W., seven and one-half years of age, admitted on July 6, 1933; discharged on September 12, 1933.

Prior to admission, the patient had a sore throat for a week; scanty urine for two days, swelling of face for two days. On admission, his skin was desquamating; cervical adenopathy and a raspberry tongue were found; blood pressure was 142/90; one plus albumin was determined on urine examination; NPN was 68 and creatin was 1.5. The diagnosis of postscarlet nephritis was made, and a nephritic low protein, low salt diet was prescribed. Five hundred

cubic centimeters of 10 per cent glucose were administered intravenously twice daily, to be replaced on July 15 by 50 cubic centimeters of a 50 per cent solution twice daily.

On July 12, six days after admission, his rather placid course became suddenly critical with all findings of acute myocardial failure. Streptococcus hemolyticus was isolated on blood culture. The patient's condition remained critical, and on July 21, the urine was smoky-red and petechiae were observed. His treatment, during this period, included stimulants, daily intramuscular blood injections and intravenous glucose. The introduction of 70 cubic centimeters of blood intravenously was followed one hour later by severe cramp-like precordial pains, vomiting, weak fluctuating pulse with a rate of 200. On August 6, the right arm and leg became paralyzed. All preceding therapy was discontinued on August 8, and to his dietary regimen were added 100 grams of liver, 8 egg yolks, 5 units of insulin three times daily, and 5 cubic centimeters of bioplastina intramuscularly.

Between August 9 and date of discharge the patient's temperature, pulse, and respiration were normal, with few exceptions; urine examination and blood chemistry was, likewise, normal; his hemiplegia and general condition were much improved.

COMMENT

Good nutrition, satisfactory immunological response to disease, and a positive nutritional balance are inseparable. With the advent of a toxemia, catabolic cellular activity surmounts the anabolic, and the nutritional balance, positive during eutrophy, becomes negative. To promote optimum cellular behavior in the toxic patient, we must provide a nutritional intake compatible with the now altered, the peculiar, physical, chemical and energy phenomena. The interpretation of physiological data described suggests a deficiency in nucleoproteins and phospholipids. These substances were added to the orthodox regimen of heterogeneous toxemias.

Liver was selected as the source of proteins. Its content in lipoprotein and other factors, many as yet undetermined, were considered essential for normal metabolism and for adequate gastro-intestinal function. Phospholipids were administered enterally, as egg yolks, and parenterally, as bioplastina (Serono).

Insulin was found clinically of advantage, and with its administration gastro-intestinal behavior appeared more sufficient. Three cases were described, and they portray the clinical response frequently obtained.

SUMMARY

1. Clinical experience suggests the probable value of nucleoproteins, phospholipids, and insulin, as adjuncts to orthodox therapy in severe toxemias.

2. The results obtained in one hundred cases, reviewed with circumspection, suggest that the frequent coincidence of clinical improvement is no therapeutic mirage.

3. The mortality rate was reduced from 30 to 8 per cent.

4. The improvement so elicited justifies additional experimentation—an intimate contemporary collaboration between internist and physiologist.

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DISCUSSION

JOHN C. RUDDOCK, M.D. (1930 Wilshire Boulevard, Los Angeles).—"There is no panacea for all ills," although one may be led to believe that this is so after reading the case reports by Doctor Tobias in the treatment of toxemias. However, I do not believe that even he needs to intimate that nutritional disturbances when corrected are the panacea for toxemias. It is my opinion that Doctor Tobias has brought to our attention in this paper certain facts which we all know but which we often neglect. Custom has caused us to apply formulas for the dietary treatment of toxic patients. Too often all we do is force fluids and load the patient up with intravenous glucose. Doctor Tobias has brought out the fact that a close coöperation between the internist and the physiologist is necessary. He has shown how it is possible to supply the physiological needs of the patient when the metabolism of that patient has been upset by toxin. His series is small but his results are good, and it devolves upon us all to give his methods a trial in the treatment of our toxic patients.

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ALBERT G. BOWER, M.D. (6777 Hollywood Boulevard, Hollywood).—While some advance is to be anticipated in future in the treatment of the acute infectious diseases by yet undiscovered specific agents, or by the coming into more general usage of factors already established but not generally available, it would appear to the clinician, who has seen many thousands of such cases, that the most urgent need at present unfulfilled in their care is for a more forward-looking handling of the involved problems of nutrition.

When scarlet fever cases began to be handled early in the disease with sweetened beverages, and little else, there was a marked lessening of the incidence of kidney involvment formerly observed. However, due to its too long continuance, and the lack of consideration of the additional factors involved, other sequelae appeared. If convalescence were successfully achieved, the patient was usually exhausted, in a poor state of nutrition and resistance, and had lost considerable weight. Under the program outlined by Doctor Tobias, mitigation of the above conditions has been pronounced.

What has been said about scarlet fever applies equally well to the other continued fevers. The change in the dietary regimen of typhoid fever, with its attendant benefit, over the past three decades is at present so well known as hardly to merit comment.

The next great advance in the handling of these diseases must result from an understanding and fulfillment of their metabolic requirements and the coöperative teamwork of the physiologist, the biochemist, the clinician, the dietitian, and the hospital director. The surface has hardly been scratched in such investigation, and from observation of the results achieved from the small beginnings so far noted, when it becomes a more intelligible and living part of our armamentarium, many lives will be saved that otherwise would be lost.

To save these lives we shall have to have enthusiastic, tireless and painstaking clinicians who approach each case as an individual nutritional problem. Also, we shall have to throw overboard the present standardized hospital diets and soft-pedal the clamor originating in the finance departments of hospitals regarding the economic phase of greatly increased costs.

I hope Doctor Tobias' paper will stimulate others to assist in blazing new trails into this more or less unexplored field, and that they may be persuaded to report their results and progress from year to year.

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George M. Stevens, M.D. (Epidemiologist, Los Angeles City Health Department, Los Angeles).—The subject discussed by Doctor Tobias is of vital importance in the management of the acute infectious diseases. The principles cited need not necessarily be confined to pediatrics, but readily lend themselves to similar conditions in the adolescent and older age groups.

The author's theoretical aspect of this subject has a sound physiological basis. He has succinctly summarized his principles of successful management by stating that "the nutrition for the toxic patient must provide an ample phospholipid and nucleoprotein intake." During my many years of service at the Communicable Disease Unit of the Los Angeles County Hospital it has been my privilege to have witnessed these principles applied to practical use. The results have been most gratifying. The principles of dietetics are often confusing. Frequently we continue with our regimen of therapeutic and dietetic management solely on the basis of precedent, and not on sound physiological knowledge. I have observed many patients who had received adequate specific medication but who clinically continued to retrogress. This, despite the fact that their diets were presumed to be adequate. Subsequently, the principles advocated by Doctor Tobias were instituted and, much to my surprise and pleasure, I noted many a dramatic and rapid convalescence, which terminated in complete clinical recovery.

I cannot overemphasize the correlation as to the value of good nutrition based on the principles of modern-day physiology and medication. These factors are essential for the satisfactory immunological response of the patient to the toxemias of the acute infections. The two are closely interwoven and are of equal importance. The principles evaluated in this article are readily applicable to our every-day practice with the most encouraging clinical results.

MAXILLARY SINUS IRRIGATION THROUGH THE OSTIA*

WITH ANATOMICAL AND CLINICAL DEMONSTRATIONS

By Charles E. Futch, M.D.
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Discussion *by Jay Randolph Sharpsteen, M. D., Oakland; Rea E. Ashley, M. D., San Francisco; Ben L. Bryant, M. D., Los Angeles.*

Nathaniel Highmore,[1] in 1651, described a suppurative disease of the nasal accessory sinus which bears his name. Since Highmore there have been innumerable treatises upon the anatomy and pathology of the maxillary sinus. Today the fundamentals of diagnosis and treatment are based upon a consideration of the work of these past teachers.

Irrigation of the maxillary sinus has long been an established procedure in diagnosis and treatment. Five methods of irrigation are recognized: (1) Cowper's[2] method; (2) approach by way of the canine fossa; (3) puncture of the middle meatus; (4) puncture of the inferior meatus; (5) cannulization of the ostia of the middle meatus. These methods are all familiar to rhinologists. This discussion, however, will be limited to irrigation by way of the ostia of the maxillary sinus. While this method is now widely used, some rhinologists may not have experienced the advantages of this approach without puncture.

HISTORY

Jourdain,[3] a dentist of Bordeaux in 1765, is said to have been the first to use the approach to the maxillary sinus through the middle meatus. The shape of the instrument used by Jourdain indicates strongly that the membrane of the middle meatus was punctured. Although the patient was relieved by this procedure, Jourdain[3] and his method were condemned as dangerous and unsafe by the French Council of Medicine. Stoerk,[4] as early as 1886, preferred the ostium technique to the then newly introduced puncture through the inferior meatus. Hartmann[5] also endorsed this method, and was able to irrigate twenty-three out of thirty-two maxillary sinuses with this approach.

LITERATURE

The literature of more recent years shows a wide variance of opinion by rhinologists of wide clinical experience. Favoring this approach, Meyerson[6] stated: "It would appear from this study that irrigation of the maxillary sinus through its ostium is a feasible procedure, in a sufficiently large percentage of cases, to make it worthy of a trial." Dintenfass,[7] likewise, states that "in the diagnosis of disease of the maxillary antrum, ostial catheterization should always be attempted before resorting to the puncture of the inferior meatus."

On the contrary, Ross Skillern[8] does not think that this method is practical, and Mosher,[9] in 1929, said: "It is difficult, if not impossible, in the majority of cases to catheterize the ostium of the antrum. From the surgical standpoint, however, this makes but little difference, because it is easy to break into the antrum near the ostium through the membranous area in which the ostium is placed." Also supporting the negative view, Sieur and Jacob[10] stated that "since the ostium opens into the lowermost portion of the infundibulum, one must agree with Zuckerkandl that 'it is entirely superfluous to tire oneself in sounding it.'" The use of the ostia for cannulization of the maxillary sinus must have some value to have merited so much consideration. The fact that the views are controversial should stimulate to further study of this problem.

ANATOMY

A review of the anatomy of the middle meatus will clarify the possibilities of approach through the natural or accessory ostia. Under the middle turbinate, anteriorly and below, there is the uncinate process, which forms the anterior inferior lip of the hiatus semilunaris. The superior posterior lip of the hiatus is formed by the bulla ethmoidalis. The divergence of these two structures, the bulla ethmoidalis and the hiatus semilunaris, is the bullo-uncinate angle. The infundibulum is the groove bounded by the hiatus semilunaris, bulla ethmoidalis and the bullo-uncinate angle posteriorly.

In this series of twenty dissections, accessory ostia were found in approximately 30 per cent.

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

The most usual location of these accessory ostia was the bullo-uncinate angle. Variability in size was observed to range from 6 by 4 millimeters to 1 by 1½ millimeters. Double accessory ostia were found in three specimens. The natural ostium, unlike the accessory ostia, was found to be a canal.

Van Alyea[11] has recently made an anatomical study of the accessibility of the ostium. In his specimens, these studies showed an accessibility of the ostia of 54.6 per cent. M. C. Meyerson,[12] in a similar series, stated that only fifteen of one hundred and fourteen (approximately 13 per cent) of his studies were inaccessible. This is a much higher percentage of accessibility than was found in my dissections, as follows: The natural ostium, in the fixed specimen, was found to be accessible in only 40 per cent of the dissections without forcing or tearing the fixed tissues. Accessory ostia made accessible an additional 30 per cent—a total accessibility of 70 per cent. This 40 per cent accessibility of the natural ostium in these dissections does not compare favorably with the accessibility stated by Meyerson.[13] The total accessibility, however, by way of the middle meatus, did approach this percentage more closely.

CLINICAL EXPERIENCE

Clinically, Lee Hurd[14] states that he has sounded the natural ostium in practically 70 per cent of his patients. Undoubtedly, a reasonable percentage of this cannulization was done through the accessory ostia. Schaeffer[15] made further clinical observations and stated that "clinically, in a vast majority of cases it is impossible to sound a maxillary sinus through its ostium." My clinical experience, embracing some 1,200 cases over a period of the past four years, does not support such a statement. In my experience, it has been possible to irrigate the maxillary sinus through the middle meatus, without puncture, in 72 per cent. By observing the position of the cannula, it is my conclusion that approximately one-third of these cases were irrigated by way of an accessory ostium. These clinical observations coincide closely with the anatomical facts of accessibility in my dissections. Meyerson[16] stated, clinically, a high accessibility of 81 per cent, which is far beyond my conclusions of accessibility by way of the natural ostium alone.

INDICATIONS

The indications for irrigation of the maxillary sinus, by way of the natural or accessory ostia, are the same indications as for other methods. This technique should never be forced, and in those cases where it is used with ease the experience is gratifying to the patient, particularly when a puncture has previously been experienced.

ADVANTAGES

The advantages of irrigation without puncture can be summarized as follows: (1) Danger of air embolism is reduced. (2) Hemorrhage is not experienced. (3) The unpleasantness of pressure is greatly eliminated. (4) Infiltration, or emphysema of soft parts, in less liable with a dull instrument. (5) Nervous patients experience less shock than when a sharp needle is forced through bone, or even membrane. (6) Where the ostium is inaccessible, anesthesia is complete for puncture through the middle meatus. (7) Shrinking the tissues of the middle meatus, even when puncture has to be performed, has the benefit of an improved aeration and drainage of the sinuses emptying into the middle meatus. (8) A patient who has experienced irrigation through the natural opening will not permit puncture.

LIMITATIONS

There are certain limitations to the approach of the maxillary sinus through the natural ostia. Most of these limitations are due to anatomical or pathological inaccessibility, such as: Anatomical—(1) Middle turbinate hypertrophied; (2) deviated septum filling the middle meatus; (3) a high uncinate process; (4) an overhanging bulla ethmoidalis; (5) an exceptionally deep infundibulum; (6) a natural ostium less than 1½ millimeters in diameter (which precludes proper exit for maxillary content). Pathological—(1) Middle meatus filled with polyps; (2) acute or chronic inflammation of ostia, resulting in contracture or closure (which usually yields to shrinking) (3) closure due to irritation of repeated cannulizations (which occurs in small ostia of marginal accessibility).

CONTRAINDICATIONS

The chief contraindication for irrigation through the natural ostium is where an ostium is found with difficulty by the operator for any reason. The prolonged manipulation of the tissues of the middle meatus cause inflammation and swelling of the tissues in that region, which swelling may block the ostia of the other sinuses emptying into this area. Some judgment must be exercised in using this method, or the benefits will be more than neutralized.

INSTRUMENTS

The number of instruments which have been devised for irrigation through the middle meatus without puncture gives further proof of the interest rhinology has long shown in this problem. The first instrument of Jourdain was a clumsy cannula, not suited by size or curve. The number of instruments collected by M. C. Meyerson[17] show a progressive refinement, and reflect further anatomical adaptation. The cannula first made by Pierce has become the model upon which most instruments used for this work are based. Early in my efforts in this field, it was observed that the choice of instruments was very limited, particularly in size and flexibility. This technique demands a wide choice of size, flexibility, and a variable angle of the tip is essential. The natural ostium, which is actually a canal, as demonstrated by myself, and even more extensively by others, may be either vertical, horizontal, or oblique in position. The silver cannula, fitted to a steel shank with a thumb rest, and made up in sizes from 1½ to 2½ millimeters, has been found in my work to be well adapted to this technique. The thumb rest has assisted in applying gentle pressure and in guiding the tip into the ostium.

TECHNIQUE

An exact knowledge of the anatomy and its variations in the region of the ostium is essential to successful passage of the cannula without trauma. Experience and observation of the nasal anatomy in each case dictates the choice of instrument. A hypertrophied middle turbinate, a deviated septum, a deep middle meatus or infundibulum, or both, and other factors as have been mentioned, must be considered. The length of the curved silver tip should be shortened in children and small noses. It is not unusual to pass a medium or even large cannula with ease in a child. This experience with children confirms that of Yankhauer and Goldman,[18] who were able to cannulize infants in the first year of life. A good anesthesia must be secured well anteriorly in the middle meatus and superiorly over the edge of the uncinate process into the infundibulum.

The cannula is used in the left hand for the left side, and in the right hand for the opposite side. The use of either hand may seem a bit awkward to the occasional operator, but the advantage of persistence in this effort will soon be appreciated. The instrument is first passed along the floor of the nose, tip upward, pointing into the middle meatus well posteriorly. It is then moved gently forward and laterally until it is felt to drop into the infundibulum, and not unusually into an accessory ostium. Manipulating the cannula further forward into the bullo-uncinate angle, the tip may be felt to engage the natural ostium, and with only gentle pressure the tip should fall into the antrum if accessible by this route. It must here be remembered that the ostium is actually a canal, and may be vertical, horizontal, or oblique. The patient should experience no pain and little pressure.

COMPLICATIONS

There have been no complications where the technique as outlined has been observed. In two cases over a period of four years, and during the first two years of my experience, too much pressure was applied and the blunt tip was passed through the naso-orbital angle of a narrow antrum into the orbit. In one of these cases there was some emphysema of the soft tissues of the orbit, and the other case showed a slight infiltration of these tissues. No pain was experienced in either case, only a sense of fullness in the region of the eye. Fortunately there was no resultant infection. Intra-antral hemorrhage was experienced in one case. Great pain was experienced by this patient for two days following the irrigation.

Resistance to pressure was noted in another case after the tip had entered the ostium with ease. This patient experienced much discomfort for thirty-six hours, when there was a sudden gush of yellow pus from the nose, with immediate relief. There was probably a purulent cyst punctured with even the dull tip, or the pressure in the antrum was so increased around the cyst, which blocked the exit of the fluid that the pressure caused it to rupture. Acutely inflamed sinuses are not irrigated unless the pressure symptoms definitely indicate such procedure.

CONCLUSION

During the first year only selected cases were attempted. The last three years, all cases which did not show distinct contraindications as mentioned, have been attempted through the ostia where irrigation was indicated. Irrigation by this method has been successful, as stated, in 72 per cent of these cases. Many cases showed profuse, granular and floccular pus in the return fluid, and cleared up with no further treatment than irrigation by this method. Where there was a persistence of purulent return without improvement in quality, or a mucoid tendency of the discharge, antrotomy or further surgery was recommended, according to indications.

Irrigation of the maxillary sinus by way of the ostia, when accomplished without extensive manipulation, is a valuable procedure, and has a distinct advantage over other methods of sinus irrigation.

SUMMARY

Irrigation of the maxillary sinus through the ostia is not a new procedure. Regardless of this fact, there is a difference of opinion by authorities as to its value, which should stimulate further investigation.

A consideration of the anatomical work presented shows a total accessibility of 70 per cent by way of the ostia; accessibility of the natural ostium, 40 per cent; accessibility of the accessory ostia, 30 per cent.

Approximately 1200 cases have been cannulized, without puncture, by way of the middle meatus in the past four years. Clinically, 72 per cent of the irrigations have been accomplished by this technique.

There are advantages of irrigation by means of the ostia which make it a valuable procedure in cases to which it is suited. There are certain anatomical and pathological conditions which contraindicate the use of this technique.

The choice of instrument and a certain skill, acquired with practice, are essential to accomplishment without excessive manipulation. The use of either hand must be developed for skillful cannulization.

Complications are unusual and less serious than those seen after puncture.

1930 Wilshire Boulevard.

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DISCUSSION

Jay Randolph Sharpsteen, M.D. (3115 Webster Street, Oakland).—We, all of us, welcome a method whereby the maxillary sinuses may be irrigated with the least possible trauma or discomfort to the poor miserable individual who presents himself with an acutely congested nasal mucous membrane and an antrum overloaded with pus.

As Doctor Futch has pointed out, the shrinkage of the middle meatus, coincident with its anesthetizing, provokes and facilitates drainage not attainable otherwise.

That Doctor Futch is successful in applying this method in 72 per cent of his attempts would seem to indicate that the native of Iowa and his Southern California descendants have much more roomy meati than narrow-nosed, gray-bound individuals so common in the more northerly portions of this great and glorious State.

I have not accurately checked my own records in this regard, but should unhesitatingly state that were I able to introduce a cannula in as many as 40 per cent of the patients, my problems would be much less difficult.

It always seems my especial misfortune to find that the patient upon whom I would particularly want to use this procedure has a host of bad nasal anatomy, which simply means two strikes called on me before I have a chance to swing at the ball.

It might very well be that, had I an assortment of middle-meatus cannulae such as the author possesses, my batting average would thereby be increased, but I merely have one size of the Yankhauer instrument.

My experience has been that when this procedure is possible, it is perfect; but I have had to resort, all too frequently, to a puncture of the lower meatus.

An important and very satisfactory use of this procedure, and one which was not mentioned, is for the purpose of filling the sinuses with radio-opaque solutions for x-ray examination. It is in this connection that I find it most valuable.

The other advantages of this method have been enumerated by the author. The disadvantages which have been my lot to observe are: (1) It is time-consuming; (2) It frequently produces more trauma in the middle meatus than is justifiable because, after all, this is the region through which drainage occurs, and the swelling, which all too frequently follows the manipulation of these already insulted tissues, often counteracts the advantages.

Both methods have been used upon me, and I cannot say that I have much choice; but I can say that I recovered more quickly and with less discomfort by puncture of the inferior meatus.

Rea E. Ashley, M.D. (384 Post Street, San Francisco). Doctor Futch's review of the subject, and his high percentage of success will undoubtedly stimulate others in an effort to obtain equally good results. After trying a method several times and failing, we are apt to condemn it, or at least discard it as a routine procedure. The paper will, I am sure, serve as a reminder to those of us who use another technique routinely, that the normal ostium method is possible in many cases.

In our office we prefer to wash the antrum by actual puncture under the inferior turbinate. We have tried both methods, and, while our experience in the normal opening technique has not been as great as that of Doctor Futch, we believe that, in our hands at least, puncture through the lateral wall has certain advantages. Some of the more important ones are: (1) the puncture method is applicable to a far greater number of cases; (2) the danger is slight; (3) with the puncture method we are sure that we have actually washed the antrum and not just washed in the general locality of the ostium; (4) the ostium is frequently so small that the cannula may almost completely close it, thus preventing free return of the solution. Solution forced into the antrum by the needle method has the advantage of the entire ostium as an exit.

We do attempt, however, the irrigation through the normal ostium in certain selected cases, *i. e.*, in those patients with heavy lateral walls where needle puncture is difficult, and also where patients have acute antra and irrigation is indicated.

Yet I must admit that the percentage of times we have been able to catheterize the normal ostium is far below the experience of Doctor Futch.



Ben L. Bryant, M. D. (2007 Wilshire Boulevard, Los Angeles).—Doctor Futch has presented a clear and interesting consideration of antrum irrigation through the natural orifice, and I have enjoyed the motion pictures particularly. They are excellent, technically, and must be enlightening to anyone who has felt that the ostium irrigation of the antrum is an unusually difficult procedure. As a matter of fact, those of us who are accustomed to using this procedure frequently feel that, with sufficient knowledge of the anatomy of the part and a certain amount of training and experience, it is certainly no more awesome to the physician than puncture through the inferior meatus and decidedly less so for the patient.

The first several hundred antra which I irrigated were done by means of a trocar introduced through the inferior meatus. I soon changed, however, to the middle meatal approach which I have used exclusively for the past seven years. In a series of several thousand antrum irrigations, it has been necessary to resort to the use of the trocar on only two occasions. I realize that this may seem to be a startling statement, particularly since I have heard a number of erudite discussions at medical meetings as to whether the natural orifice can be entered in 47 per cent, or 53 per cent, or 61 per cent of patients. Of course, I do not feel that my cannula has entered the natural ostium in every instance. In many cases, the accessory ostium was utilized and, in some, the neighboring membrane was punctured. Sufficiently exhaustive and painstaking anatomical studies have been made of the region in question to show that there is a wide variation in the size, form and relative location of both natural and accessory ostia, and a knowledge of the usual and of the unusual locations of these openings is naturally a prerequisite for the use of this method. A further requisite is a careful and complete anesthesia of the part.

My technique has been to shrink the membranes of the middle meatus and the adjacent area first with a pledget impregnated with 2 per cent cocain solution, following this with 20 per cent cocain locally on a small cotton-wrapped applicator, the cocain in both instances being replaced by pontacain in patients who are known to possess a sensitivity to the former. When this has been done to the point where the patient is entirely free of sensation in this region, a small Ritter frontal sound is used as a probe to locate the ostium, or accessory ostium if it is more accessible. If, as is sometimes true, neither can be located without displacing the middle turbinate, a surprisingly slight pressure on the

Ritter sound will carry it through the membrane. After the opening has been located, the blunt cannula of the Killian type can be introduced. In certain cases, due to the topography of the surrounding area, a Spilberg blunt cannula can be used more easily.

Regardless of whether the cannula passes through one of the ostia, as it does in the majority of the cases, or through the middle meatal membrane, as it does in a small percentage of cases, the advantage of this method over the inferior meatal puncture with the consequent trauma, hemorrhage, and opening of new lymphatic and vascular pathways is obvious. One still hears the idea propounded occasionally that the inferior meatal irrigation is better because it affords drainage in the dependent portion of the antrum. This idea is nebulous at best, for the opening made by the trocar closes almost immediately, and even if it did remain open, the experimental work done by Hilding and others has shown conclusively that the ciliary activity of the antrum membrane continues to carry the secretions to the natural ostium in the middle meatus regardless of what has been done in the inferior meatus.

In addition to this, there is the matter of comfort to the patient. That there is a great difference in this respect I can bear witness personally, having had my own antrum irrigated in the past by both methods. I find that it is most unusual to have a patient dread an antrum lavage after the middle meatal approach has been used, even though he feared it greatly on the basis of former experiences with the inferior meatal approach.

Emphasis should be placed on the importance of avoiding any form of antrum irrigation in the presence of acute inflammation. If this rule is observed, and acutely inflamed membranes or an elevation in temperature are considered steadfastly as contraindications for antrum lavage, there will be no need to fear a general constitutional reaction. If this is not observed, high fever, chills, and severe consequences may result.

PRIMARY TUMORS OF THE URETER*

By Jay J. Crane, M.D.
Los Angeles

Discussion *by A. J. Scholl, M. D., Los Angeles; Charles Pierre Mathé, M. D., San Francisco; Paul A. Ferrier, M. D., Pasadena.*

PRIMARY tumors of the ureter are seldom encountered. Snyder and Wood, reviewing the literature in 1933, placed the number of proved cases at seventy. O'Brien, this year, added a case, bringing the total to seventy-one. The case I have to report not only makes the total seventy-two, but furnishes a classical description of this unusual pathological lesion.

REPORT OF CASE

Mr. H. E., Case No. 164136, age fifty-four, married, white, and a meat cutter by occupation, was first seen April 18, 1935, complaining that he had noticed mass growing in the left side of the abdomen for the past one and one-half years. During the week previous to our examination, he had become nauseated and had suffered with general aching, for which he consulted a chiropractor who had given him a spinal adjustment, which was followed by a severe pain in the lower part of the back and abdomen. Upon further questioning, the patient stated that he had not been inconvenienced by the growth or pain to the extent that he could not carry on his work as a meat cutter. However, he did mention that he was progressively having more difficulty with his bowels in that he was constipated and suffered considerably with flatulence; yet he denied ever having noticed bloody urine and said he was not having any bladder disturbance to speak of, except a little more frequency night and day than usual. He thought that his symptoms, as just mentioned, had become more noticeable as the tumor grew larger.

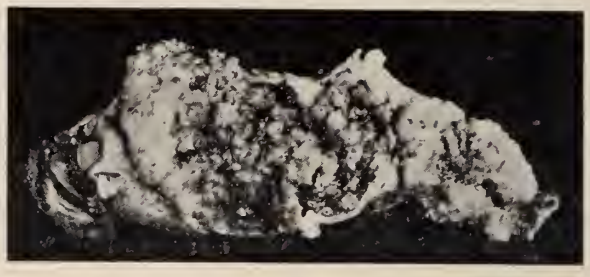


Fig. 1.—Primary tumor of left ureter.

Examination.—On April 24, 1935, at the time the cystoscopic examination and kidney study was first done, the abdomen was filled with a very large tumor mass which was smooth, firm and tender, and which, upon palpation, felt to be full of fluid. The size of the abdomen resembled that of a person suffering with a far-advanced ascites in that the skin was glistening and the abdomen extremely distended. The external genitalia and prostate were normal.

A No. 24 French cystoscope passed readily into the bladder, which was normal yet difficult to distend because of the pressure of the mass above. The ureteral orifice was readily visualized and appeared to be normal. Clear jets of urine were seen spurting from the right orifice, while from the left ureteral orifice several small papillary growths were seen protruding. Indigocarmin was given intravenously before attempting to catheterize the ureters; it appeared from the right side in three and one-half minutes in exceptionally concentrated jets, which were vigorous and forceful, while on the left side no dye appeared at the end of thirty minutes. A No. 6 French ureteral catheter passed to the kidney pelvis on the right side, the urine dripped through the catheter spontaneously and clear, while on the left side the catheter was obstructed at 10 centimeters and with each attempt to pass the cather further a gush of fresh blood poured out of the ureteral orifice alongside the ureteral catheter.

Bilateral ureteropyelograms were taken. Those of the right side represented a normal ureter and kidney, while those on the left disclosed a filling defect in the lower end of the ureter. (See Figure 3, which was not unlike the filling defect produced in a ureter by a tumor.) Unsuccessful attempts to obtain biopsies of the protruding papillary tumors were made. From the above findings of a tumor in the abdomen and a filling defect in the left ureter, a diagnosis of a large hydronephrosis was made. It was thought at this time that probably the kidney was full of papillary tumors.

Operation.—At operation, on April 26, 1935, the large hydronephrosis was drained through the left costovertebral angle. At the same time the abdomen was explored and 3,500 cubic centimeters of fluid was removed, and a biopsy of the wall of the hydronephrosis proved not to be malignant.

The patient left the hospital in two weeks, and ignored further advice and treatment until, one year later, the drainage had ceased and the hydronephrosis had refilled approximately to its former size.

Course.—A second cystoscopic examination on April 26, 1936, a year later, disclosed the filling defect to be present, and also a papillary tumor growth situated on the tip of the left ureteral orifice, a biopsy of which proved to be a papillary tumor with no essential malignant features. A few days after the second cystoscopic examination the hydronephrotic sac was removed with great difficulty. The ureter was sectioned at junction of the middle and upper third. At this point no tumor was encountered in the ureter.

Pathological Report.—The pathological report of the hydronephrotic sac was as follows: "Specimen consists of a hydronephrotic sac or mass of tissue which weighs 545 grams. Microscopically, areas of old hemorrhage and hemosiderin and cholesterin crystals with foreign body

*Read before the Urology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.



Fig. 2.—Partially filled hydronephrosis of the left kidney caused by obstructing tumor in the ureter.



Fig. 3.—Filling defect at lower end of the left ureter caused by tumor.

giant cell formation are seen. There is no evidence of malignancy of tubercles present."

A month later the remaining part of the ureter with a section of the bladder was removed, the pathological report which is as follows: "The specimen consists of a tumor mass of ureter 12.5 by 5 centimeters in diameter. The tumor mass is well circumscribed, is yellow and friable. The tumor projects 10 millimeters within the wall of the ureter.

Microscopic Diagnosis.—Infiltrating epidermoid carcinoma of the ureter, grade three.

SUMMARY

The findings, which lead to the diagnosis of a ureteral tumor in this case and which I consider as classical, were:

1. Papillary growth seen at the left ureteral orifice.

2. Free bleeding with each attempt to catheterize the left ureter.

3. Filling defect in the left ureter, which was present on two occasions one year apart.

4. Palpable tumor in the abdomen.

Early ureteral tumors are easily overlooked unless one or more of the above findings are found, for hematuria and ureteral colic are not pathognomonic. Good, clear ureterograms are as important as pyelograms, and should be routinely made at the time of each kidney study. By so doing, I am sure more of these seldom encountered tumors will be found.

1921 Wilshire Boulevard.

DISCUSSION

A. J. Scholl, M.D. (523 West Sixth Street, Los Angeles).—Carcinoma of the ureter occurs at a relatively early age, compared with malignant tumors of the other organs. In reported cases, about one-third were in persons under fifty years of age. Many of these tumors, as in Doctor Crane's case, are found in the lower part of the ureter, as more than one-half are localized there. They not infrequently occur at the normal points of ureteral constriction, namely, the two extremities and the brim of the pelvis. Doctor Crane's case was one of epidermoid carcinoma, with a high grade of malignancy. Histopathologic data given in a recent series of seventy-five cases, reported by Bergendal, are of interest: there were 38 cases of papillary carcinoma, 12 of squamous-cell carcinoma, 20 of carcinoma simplex solidum medullare, 3 of adenocarcinoma, and 2 of transition-cell carcinoma.

There are three common types of ureteral carcinoma. The first is the sharply outlined tumor which varies in size from that of a pea or cherry up to that of a pigeon's egg, and which fills the lumen and springs from the ureteral wall by a not infrequently narrow pedicle; the surface may be smooth, moderately uneven, split up or papillomatous and cauliflower-like. In the second, or the infiltrative, type the growth invades the ureteral wall for a shorter or longer distance, mostly circularly, constricting the lumen to a greater or lesser degree. If only a short part of the ureter is involved, it may be difficult to determine macroscopically whether a benign stricture or a malignant process is the source of the trouble. On the other hand, cases have been described in which the tumor tissue advances and infiltrates a large portion of the ureter. In the third, or multiple, type, the gross appearance may so nearly resemble the picture of multiple papilloma that it is surprising when the malignant nature of the process is discovered at the microscopic examination or manifests itself by metastasizing via the lymph passages. The microscopic structure of carcinoma of the ureter may vary.

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Charles Pierre Mathé, M.D. (450 Sutter Street, San Francisco).—Doctor Crane has added a case of primary carcinoma of the ureter to the literature, thereby emphasizing the importance in recognizing this rare and obscure condition which offers such difficulty in diagnosis. In 1934 I had the pleasure of presenting a paper on primary carci-

noma of the ureter before the Urological Section of the California Medical Association, reporting a case which was diagnosed prior to surgical intervention consisting of nephro-ureterectomy, unfortunately too late, as the patient died seven months later from generalized metastases.

Early diagnosis of primary carcinoma of the ureter is a well worth while objective, as surgical removal offers the only chance of cure. In reviewing the literature in 1934, I found that Crane and Knickerbocker reported an eight-year cure, and Kraft an eleven-year cure, both by employing complete nephro-ureterectomy. Most of the patients treated by nephrectomy and subsequent ureterectomy died later from metastasis. In view of these statistics, one should always attempt to employ complete nephro-ureterectomy as the method of surgical attack for carcinoma of the ureter.

One should always think of primary carcinoma of the ureter in patients presenting general symptoms of cancer, and who present a triad of symptoms consisting of hematuria, lumbar pain, and tumefaction of the kidney, in whom ureteral obstruction is encountered, and in whom one can reasonably rule out stone, ureteral stricture and tumor of the kidney. The hematuria of primary cancer of the ureter, as of other cancers of the urological tract, is often microscopical in nature, but is usually present. Doctor Crane has covered the salient points in establishing a positive diagnosis. Unfortunately, in some patients in whom the tumor has occluded the lumen of the ureter, one is unable to pass by the obstructing growth in order to perform retrograde pyelography, and advanced destructive hydronephrosis will not permit secretion of opaque media injected intravenously, and in these patients the characteristic filling defect of the ureter is not to be obtained.

Additional reports of these rare cases of cancer of the ureter will keep us cancer-minded and make us be on the lookout for these obscure conditions.

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Paul A. Ferrier, M. D. (65 North Madison Avenue, Pasadena).—Primary carcinoma of the ureter has been regarded as so rare that it is not often considered in diagnosis.

Doctor Crane mentions seventy-one proved cases. In the last four years Dr. A. G. Foord has encountered four additional cases at autopsy at the Huntington Memorial Hospital, Pasadena. These will be reported in detail later. They had not been seen by a urologist, and some of them had been diagnosed as ovarian tumors. I have operated on one further unreported case which proved to be a squamous-cell type, originating about midway in the right ureter. It had encircled the lumen, causing a complete closure. It blocked the venous return of the lower half of the ureter so that there were varicosities under the mucosa, causing profuse bleeding. The pyelographic media could not be injected beyond the carcinoma. All that could be diagnosed about the kidney was that it was not large to palpation and not tender. No intravenous dye was secreted. The preoperative diagnosis was tumor of the ureter, possibly secondary to tumor of the kidney. This being suspected at the primary operation, a complete nephro-ureterectomy was done. The ureter was adherent to the common iliac vessels at the brim of the pelvis, and it was with some trepidation that they were freed. It was realized that carcinomatous tissue had extended beyond the ureter. The patient lived two years and died of generalized carcinoma.

In a large number of reported cases a nephrectomy has been done primarily and later a ureterectomy. While the nature of the case will often prevent a preoperative diagnosis of carcinoma of the ureter, such diagnoses have been made and substantiated, as in one case which I saw with Doctors Carl Rusche and S. K. Bacon. This was later proved at operation. In this case a filling defect in the ureter was observed, with rapidly advancing hydronephrosis.

One naturally thinks of papillary tumor of the renal pelvis with implants down the ureter, and in many cases this cannot be excluded. It is at least worth while to be prepared to do a complete nephro-ureterectomy in case of suspected tumor of the ureter.

I observed Doctor Crane's case in surgery. The dense perirenal adhesions and infiltrating growth made surgery extremely difficult.

STOMACH MUCOSAL CHANGES IN A-AVITAMINOSIS*

By Alvin J. Cox, Jr., M.D.
San Francisco

Discussion *by Garnett Cheney, San Francisco; A. G. Foord, M. D., Pasadena.*

FOR a number of years there have been reports in the literature concerning lesions in the stomach in some way related to dietary deficiencies, but there has been little correlation between the type of deficiency and the type of lesion produced. Clinically, this subject has been discussed by Stepp, who pointed out that there need not necessarily be a deficiency in the diet, since destruction of the vitamin in the gastro-intestinal tract, or failure of absorption, may produce deficiency in the body.

STUDIES ON ANIMALS

Of the many observations on different kinds of animals suffering from the effects of vitamin deficiencies of various sorts, most of the studies of the stomach have been made on the rat. Here the bulk of the reported changes have occurred in the fore-stomach, or squamous epithelium-lined rumen portion, and so have no counterpart in the stomach of man. Pappenheimer and Larimore, in 1923, thought ulcers in this region were due to ingested hair. A number of authors have found gastric ulcers in rats on diets deficient in vitamin B, and a few have been convinced that vitamin A deficiency was the cause of similar lesions, though in the complete study of vitamin A deficiency by Wolbach and Howe, in 1925, no gastric lesions are mentioned. Recently, Howes and Vivier have reported evidence to indicate that some substance present in whole yeast, but not in yeast extracts, is important in preventing development of ulcers in the rat stomach. Of importance in this connection are the current reports of frequent ulcers in the gizzards of chickens fed diets deficient in a newly separated fat soluble dietary factor referred to as vitamin K.

In short, there is evidence that ulcers develop in the stomach of animals of various species more readily when the diet is not adequate, but the type of deficiency is not agreed upon by the different authors.

VITAMIN A DEFICIENCY

My relatively few experiments have been confined to the study of vitamin A deficiency, and the positive evidence derived from carefully controlled experiments indicates that deficiency of this, or some closely associated substance, in the diet of albino rats is of etiological importance in the production of ulcers, not only in the rumen portion, but in the glandular portion of the stomach toward

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The experiments reported in this communication were carried out in the Pathological Institute of the University of Freiburg, Germany. Further details, as well as microphotographs of the tissue changes, may be found in Ziegler's Beiträge zur path. Anat. u. z. allg. Path. 98:362, 1937.

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the pylorus and along the lesser curvature; in other words, in the parts of the stomach commonly the site of peptic ulcers in man.

EXPERIMENTAL STUDIES

White rats of two different age groups (seven and fourteen weeks) were used, and each group control and test groups of four animals were selected. Individual cages were used, and a vitamin A-free diet, prepared according to Wolbach and Howe, was administered in controlled quantities. The control diet differed from the experimental diet only in that it contained butter instead of lard as a source of fat. The older animals were killed after seven weeks on the diet, and the younger ones were allowed to live (approximately ten weeks) until they would no longer take the prescribed quantity of food. They were then killed before they had been without food more than twenty-four hours. In the first group of animals no lesions were found in any organs; but in the second, aside from the well-known epithelial changes characteristic of vitamin A deficiency, all of the experimental animals showed small ulcers in the pyloric portion of the stomach, particularly at the lesser curvature. These ulcers were tiny, not over one millimeter in diameter, had elevated margins, and microscopically, although there was a surrounding inflammatory reaction, they showed no evidence of chronicity in any portion. They were certainly acute lesions. One animal showed eight such lesions, and all ulcers found were confined to the portion of the stomach lined by mucus-secreting pyloric glands, where there was also an increase in visible intra- and extracellular mucus. The fundus mucosa showed no changes of any kind, and the rumen portion showed only small nodular proliferations of the epithelium except for several small ulcers in one animal.

COMMENT

These mucosal lesions cannot be considered specific for vitamin A deficiency, in the first place, because other things may produce ulcers in this portion of the stomach, and, secondly, since the ulcers were all very recent, perhaps occurring during the terminal period of starvation before the animals were killed. The control rats were also starved before being killed, so it is concluded that, although in themselves the ulcers are not specific, the circumstances under which they appeared were not adequate to produce ulcers in the control rats—with the exception of one very tiny erosion in the stomach of one control animal, seen only during routine serial sectioning of the stomach.

These findings in the vitamin A-free rats might be interpreted in one of two ways: as results of injury to a normal mucosa by something abnormal in the environment, such as an increased HCl content of the gastric juice, or as the effect of injury to an abnormally susceptible mucosa by substances normally present—in my experiments augmented by the terminal period of starvation.

The first possibility is made less attractive by the clinical data of Stepp, Boller, Will, and others, indicating that, in man, vitamin A deficiency is associated with a decrease in gastric acidity, and by experimental work of Verder and Petran in monkeys which showed no change in the gastric secretion during periods of vitamin A deficiency.

Evidence of change in the cells of the stomach mucosa of my animals were demonstrable only in the mucus-secreting cells. In every case the acid-secreting portions of the mucosa were structurally normal. Only the mucus-producing pyloric glands showed evidence which might indicate increased susceptibility to injury. In addition to the ulcers, the mucosa in this area showed the increase in intra- and extracellular mucus above referred to. In considering the question of whether this increase in mucus is related directly to an increased vulnerability of the cells, one must, of course, consider the possibility that it represents merely an accumulation due to decreased digestion by the gastric juice. This, however, would not explain the accumulation within the cells. It seems more likely that an actual increase in mucus secretion existed. With special staining reactions I was unable to detect any difference in character of this mucus from that normally covering the mucosa of the rat stomach, so there is no reason to believe that the mucus was deficient in its protective action. I think it more likely that the increased mucus production is a compensatory mechanism on the part of the less-resistant mucosal cells.

Whether this change in the rat stomach has any counterpart in man is difficult to say, but it is possible that the reports by von Bergmann and others, of an increased incidence of peptic ulcer, during the spring, represents a result of decreased vitamin A intake during the winter months. A relationship between this incidence of human peptic ulcers and ulcers in the rat is suggested by the results of Siebert's observation that histamin more readily produces peptic ulcer in the rat in the spring than at other times.

IN CONCLUSION

Apart from such speculation, I believe the reported experiments have demonstrated a definite change in the glandular mucosa of the stomach of rats on a vitamin A-free diet predisposing it to injury by the gastric juice. Presumably, the exciting cause in my animals was a twenty-four-hour period of partial starvation, with failure of neutralization of the gastric juice in this period. Possibly other irritating substances might have acted similarly. As nearly as could be determined, the dietary substance protecting against these changes was vitamin A, though the possibility of some other vitamin in butter being important has not been absolutely ruled out.

Stanford University Hospital.

DISCUSSION

Garnett Cheney, M.D. (210 Post Street, San Francisco).—Any experiments attempting to correlate pathological changes in the gastric mucosa with a dietary deficiency are most welcome. Evidence is gradually accruing that such a deficiency is one important factor and, perhaps, a basic factor, in the development of certain types of gastritis and of peptic ulcer formation. Improvement in atrophic gastritis coincident with liver therapy is an established clinical fact. The seasonal variation in the incidence

of peptic ulcer may well be due to changes in diet, and a number of authors have stated that "the vital resistance" of the gastric mucosa is dependent upon an adequate vitamin intake. The nature of this vitamin is unknown to date.

In the chick experiments referred to by Doctor Cox, an erosive gastritis is an almost constant finding when the birds are fed on a diet lacking in fresh greens, but containing adequate amounts of vitamins A, B, C, and D. The gastric lesions may be prevented by the addition of certain fresh greens and cereals to the diet, or cleared up by the subsequent administration of these same substances. The antierosion substance is not vitamin K, the antihemorrhagic vitamin, but is also fat-soluble, and has its origin in the same foods as vitamin K. It has not yet been satisfactorily isolated.

It is not unlikely that the gastric lesions produced in rats may, in reality, be due to a deficiency of this unknown antierosion factor. It, as well as vitamin A, is apparently lacking in the diet used by Doctor Cox. Such an explanation of the development of these ulcers in rats would account for the confusion which has heretofore existed in this field of research. Further experiments directed toward clarifying this important subject are urgently needed.

A. G. Foord, M.D. (749 Fairfax Avenue, Pasadena).—Doctor Cox's paper is of interest chiefly because of the almost negative results obtained by extreme deprivation of vitamin A, even to the point of producing characteristic epithelial changes in other organs. The author shows good judgment in not overemphasizing the minute ulcers, or rather acute erosions, found in these badly diseased animals. In human beings superficial erosions of the stomach mucosa are not uncommonly found in a variety of conditions, especially following minute hemorrhages in the mucosa, interpreted usually as preagonal in origin. Possibly the ulcers in these rats are the consequence of similar small hemorrhages, or, as the other states, due to some effect apart from the specific avitaminosis. The fact that they are acute ulcers leads one to believe that vitamin deficiency plays little rôle in their formation. Were they specific, one should expect ulcers of varying ages and sizes.

THE LURE OF MEDICAL HISTORY†

STATE MEDICAL ASSOCIATION AND OTHER REMINISCENCES

By Douglass W. Montgomery, M.D.
San Francisco

PART I*

IT is indeed a pleasure to receive this testimonial‡ from my colleagues, and it is well worth while to have lived seventy-eight years and to have practiced medicine for fifty in order to receive it.

EARLY MEETING PLACES OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY

The honor taking place in such delightful surroundings accentuates its value. We may fittingly recall in this, our annual meeting, the energy and foresight of the late Reginald Knight Smith and his comrades who secured this beautiful home for us.

Our meetings used to be held in Shiels Hall on O'Farrell Street, where is now the City of Paris store. We were there but for the evening; it was no home; and it was the meeting place of some secret society, I do not know which. It did not furnish, through its professional atmosphere, much medical inspiration. We had, however, many a good meeting in it.

ON BOOKS

The few books and magazines received were taken care of by Mr. Duncombe, who kept a medical bookstore on Sutter Street. Duncombe afterward established an ambulance service.

After a time, with the natural accumulation of journals, the space available by Duncombe became too narrow, and I took the library until we secured quarters in the Spring Valley Building, now the City of Paris.

I recall an amusing instance showing the temperament and the relationship of two interesting men of that time. Dr. Harry M. Sherman occupied offices with Dr. George Chismore. Sherman was a bit masterful and in some ways took charge of Chismore, who was amenable and long-suffering with the vagaries of his friend. It occurred to Sherman that Chismore had not enough genitourinary literature for a man whose practice was rapidly tending that way, so he went to Duncombe's bookstore and ordered all available books. On their arrival he stacked them beside Chismore's bed, and Chismore dutifully read down through the pile.

AN EARLY MEDICAL OFFICE

When I came to San Francisco I rented two rooms in a two-story frame building on the northwest corner of Sutter and Mason streets. The rooms were a front and back parlor, the usual type of medical office at that time. They had none of the conveniences such as running water, etc.; they were just furnished rooms. There was a row of such residences on the south line of Geary Street between Powell and Stockton, all occupied by doctors' offices. It was called Murderers' Row, and the old surgery, with its heavy death rate, deserved the epithet.

SAN FRANCISCO DURING MY EARLY DAYS

The sidewalks were of wood. When those on Market Street were torn up, gangs of youngsters followed the workmen to pick up the coins that had dropped through the cracks during years of use.

The streets were cobbled. Recently, on visiting Mexico, I met with this kind of pavement and it gave me a homey feeling. The street-cars were horse-drawn, as were all the vehicles of the town; and the horses were, of course, accompanied by swarms of flies, which were excellent carriers for streptococci, furnishing the medical profession with lots of impetigo cases.

It was a dusty city, clouds of which blew about, and we did not have to prescribe calcium—we swallowed amounts of it.

The west wind, the horse droppings, and the sand, were an enduring plague only conquered on the arrival of the bitumen pavement; and with the sand came the fleas. To these latter many people were exquisitely sensitive, and one of my friends,

† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* Editor's Note.—This paper will appear in two parts.

‡ For tribute to Dr. Douglass W. Montgomery, and resolution unanimously voted at the meeting of the San Francisco County Medical Society, on December 14, 1937, see California and Western Medicine, January, 1938, p. 63.

Dr. Alec Whittell, used to take to the theater a bottle of ether. On feeling a flea he would remove the cork and press the mouth of the bottle over the tingling locality. Iron sleep would descend upon that flea.

The defective sewers gave us plenty of typhoid fever, and its care furnished a good living for many physicians. There were localities where this disease was more frequent. I remember one on Powell Street between Sutter and Post.

THE DRESS AND ROLLING EQUIPMENT OF MEDICAL MEN

I have seen the equipage, dress, and demeanor of medical men change. The tall hat that disappeared from London with the Great War had, in San Francisco, been previously eliminated by the earthquake. The frock coat accompanied the high hat, and the dress and deportment of the physician became indistinguishable from that of the business man, leaving the clergyman the only uniformed professional. The automobile displaced the doctor's carriage, his most striking equipment. Those variations from the dull democracy in dress of our male population can never return. We shall never again see Doctor von Hoffman's beautiful coach with his coachman in livery on the box, driving a span of prize horses; nor McNutt, with his tall white hat of striking shape, seated in his carriage and accompanied by his spotted coach dogs. He was often called Doctor McHat, and the nickname did not need explanation. Doctor Parsons, austerely seated in his lofty carriage, dressed in his London-tailored clothes and with a shirt collar that buttoned nearly as low as an ordinary vest, is a memory of the unreturnable past. Dr. J. H. Stallard was another Englishman, and it occurred to him to send home for a hansom. It was a unique vehicle, and resembled an upright coffin on trunnions. It was drawn by a powerful horse, a gift to the doctor from George Hearst, the father of the proprietor of the *San Francisco Examiner*. Instead of having a coachman perched high in the rear over the roof of the carriage, it was driven by the doctor himself, the reins passing through a slit in the front of the "coffin." When the doctor, with his white flowing side whiskers, his black frock coat, his stovepipe hat, and his saucy lap dog seated beside him, drove forth in his peculiar showcase, he was one of the sights of the town.

Once, while standing on the corner of Fourth and Market streets, and seeing carriage after carriage drive by, I inquired what it meant. Some well-to-do person, I learned, was ill in one of the swell districts of the city—Rincon Hill. There is a small nub of this hill still remaining. First a street was cut through, destroying its fine lines, and recently the San Francisco-Oakland Bridge has finished it off, except for the aforesaid nub.

LISTERIAN THERAPY

When I came to San Francisco the Listerian therapy was just arriving, and its arrival meant a major disaster to the older surgeons. The human being, especially when elderly, is intolerant of new ideas. Many of these surgeons were competent men and good workmen, but they could not grasp the relevance of the minutiae and excessive cleanliness required by the new technique. Now the idea of this cleanliness has become generalized among the laity, and leads often into the most ridiculous byways.

A surgeon's income, when in full practice, may be large, but with the years this naturally decreases. Formerly an elderly surgeon often made a comfortable living by consultation, but this source of income has no longer the vogue it used to have.

450 Sutter Street.

(TO BE CONTINUED)

A HARVEIAN PILGRIMAGE

By GEORGE H. EVANS, M.D.
Berkeley

ON a hill overlooking the quaint old village of Hempstead, in Essex, England, seven miles distant from the nearest railroad station (Saffron Waldon), stands a picturesque little parish church. The first church there was built in the twelfth century, with walls and some pillars in the chancel of Norman architecture; and now that the tower crumbled and fell to the ground in 1882, these are all that is left of the old edifice. The nave is early Gothic. This church is of particular interest to medical men because within it lie the mortal remains of William Harvey, the world's greatest physiologist—the discoverer of the circulation of the blood.

The Harvey Chapel is situated in the left transept of the church. It contains the marble sarcophagus provided by the Royal College of Physicians, into which, on October 18, 1883, in the presence of several Fellows of the College, Harvey's lead coffin and its contents—which had been removed from the vault beneath the church where they had rested for 226 years—were reverently placed, together with a copy of a large edition of Harvey's works and a Roll recounting the incidents of the transposition of the remains.

The Chapel also contains a bust of Harvey, attributed to Scheemakers, and memorial tablets of other members of the Harvey family.



Fig. 1.—Burial place of William Harvey, Parish Church at Hempstead, Essex, England.

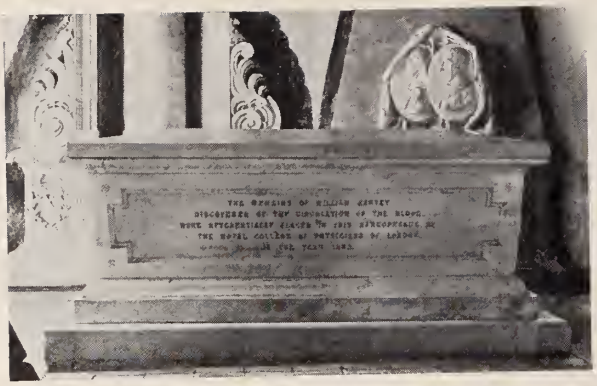


Fig. 2.—Sarcophagus in the "Harvey Chapel," Church at Hempstead. Contains the remains of Harvey.



Fig. 3.—Marble bust of William Harvey in the Harvey Chapel. Bust ascribed to Scheemakers.

It must have been a sad group of mourners who, on that day in June, 1657, set out from London on their dreary journey of almost fifty miles, accompanying the mortal remains of their beloved Fellow to their last resting place in the family vault under the parish church at Hempstead. At that time the prevailing method of burial was the encasement of the body in a lead coffin. These coffins resembled Egyptian mummy cases; the bodies were simply lapped in lead and provided a poor protection against the disintegrating forces of time and unfavorable climatic conditions. It was here in this vault, immediately under an open-grated window, that the remains of the Master were placed at rest with his ancestors. It was not until 1859, however, that a Committee of the Royal College of Physicians, among whom were Quain and Stewart, visited the burial place in Hempstead. They found forty-six coffins in the vault, several of which had collapsed in part, leaving concave upper surfaces filled with water, which seeped into the interior of the coffins through fissures in the lead. Ventilation in this vault was attained by three open-grated windows, which offered no protection from rain. Harvey's coffin, situated immediately under one of these windows, was in a particularly bad state of preservation. The concavity was filled with dirty water and there was a large rent in the lead cover.

The president of the College requested permission of the family to be allowed to make necessary repairs for the better preservation of the remains. This was refused, though he was later informed that the family had made such repairs.

In April, 1937, I visited Hempstead, and was well repaid for the rather tiresome journey from London for the privilege of standing beside the remains of the great physiologist, whose achievements have meant so much to the science of medicine.

Through the courtesy of the vicar, the Reverend T. P. Conyes Barker, and his wife, I was given the opportunity of visiting the church and the vault underneath. A trap door and a staircase situated outside the church afford entrance to the vault. The recent rains had flooded the flooring, and in places one waded ankle-deep in water. The coffins, all in a bad state of preservation, were lying directly on the floor. The brick walls directly supporting the Harvey Chapel above were water-soaked. One coffin, badly broken, exposed its contents, which consisted of a few bones and a dark, dirty-looking gelatinous granular mass. The body was entirely disintegrated. It is doubtful if a better state of preservation exists in the contents of the lead coffin in the Harvey sarcophagus.

I feared that the supports in the vault, probably damaged by time and exposure, were not sufficient to safely support the weight of the sarcophagus in the chapel immediately above. This was communicated to officials of the Royal College of Physicians, who, however, assured me that regular inspections are made by the College from time to time.

It is not intended here to go in detail into the life and achievements of Harvey. These are well known to the student of medical history. Twenty-six years had elapsed since Harvey, inspired by the teaching of his illustrious master, the anatomist, Fabricius ab Aquapendente, left Padua, before he published, in Frankfort, 1628, his immortal treatise, "Exercitatio Anatomica de Mortu Cordis et Sanguinis." Padua, at the end of the sixteenth century, was the world's center of medical learning

and accomplishment. The great Vesalius had done much to tear down Galenical dogma and had laid the foundation for the development of modern medical science. His successors, Realdo Columbo and Andrea Cesalpino, had each made contributions to blood circulation, as had Servetus previously in Paris. Falloppio, first at Pisa, then at Padua, enriched anatomical knowledge by his description of the fallopian tubes, the oculomotor muscles, the cerebral nerves, the chorda tympani, the semicircular canals, and the aqueduct. Padua had become a great medical school. A brilliant coterie of men surrounded Fabricius when Harvey entered the halls of Padua in 1598.

There is some doubt that the preliminary work of Cesalpino and Columbo on the circulation made a deep impression upon Harvey, then only twenty years of age. In the manuscript room of the British Museum exist some original notes of Harvey's for his lectures on Universal Anatomy, delivered on April 16, 17, and 18, 1616. In these lectures he made his first public statement of his discovery of the circulation of the blood, twelve years before the publication of the Frankfort treatise. Priority for the credit of the discovery of the circulation of the blood has been bitterly contested in Italy, but the advocates of Cesalpino, Columbo, and Servetus have tried in vain to snatch the laurel wreath from the brow of Harvey. During the passage of almost three hundred years since his death the convincing records of eminent historians clearly place to Harvey the credit for his epochal demonstration. Of these many contributors should be particularly mentioned the treatise of Prof. Max Neuburger of Vienna, published in 1930.[1]

The published works of Harvey are comparatively few. Aside from his great treatise, the most important is his work on the generation of animals, "Exercitationes de Generatione Animalium, quibus accedunt quædam de Partu de Membranis ac Tumoribus Uteri, et de Conceptione," published in 1651. Aside from these, his published writings are: "Two Disquisitions to Riolanus"; "A Short Report of the Postmortem Examination of Thomas Parr"; and a few letters to Caspar Hofman, Slegel, Nardi, Morison, and Horstius in explanation or defense of his views.

In the Sloane collection in the British Museum, there is a portion of an unpublished manuscript of 121 leaves devoted to "Anatomy of Muscles: Their Functions and Diseases"; also his original notes of lectures on Universal Anatomy, to which reference has already been made. In all probability some of his works were lost when his lodgings in Whitehall were plundered during the civil wars, and when the home of the Royal College of Physicians, to whom he had bequeathed all his books and papers, was destroyed in the great fire of 1666.

78 The Uplands.

1 Neuburger, Max: "Zur Entdeckungsgeschichte des Lungenkreislaufes," Wien. Südhoffs Archiv für Geschichte der Medizin, Band 23, Heft 1, 1930.

CLINICAL NOTES AND CASE REPORTS

WHAT DOES "NEUROTIC" MEAN?

By R. P. Little, M.D.
Santa Paula

WHAT is a neurotic? The dictionary says it is one who is afflicted with a neurosis, and that a neurosis is a functional type of nervous disorder, or one without an evident organic or structural basis. But this is a mere classification for convenience, and befogs thought, for there is really no fundamental distinction. We believe that structure conditions function. Thus the term merely denotes a difference in the degree of structural change. The gross and readily perceivable changes being known as organic, and the obscure as functional, and physicians often infer that the patient can change his composition by an effort of will and that all he needs to do is think he is well and he will be so. This is indeed mysticism. The doctor, in his helplessness, may even become exasperated and relieve his feelings by adopting the attitude of contempt, which is merely a defense for ignorance.

Let us consider neurotics at greater length. As used the term is not specific, but is a pigeon-hole for odds and ends of nervous disorders. It is a wastebasket term for which there is no specific criterion except that it relates to the nervous system. The cause must be obscure, for, if it is evident, troubles are classified under that heading. Neurasthenia and epilepsy have little in common, yet if they occur in the "family tree" it is said to have a neurotic taint. Neurasthenia is characterized by a lack of energy, and epilepsy by fits.

Let me tell of a few neurotics that I have known. They were classified as such by medical men:

Case 1.—An interne was once awakened at about 2 a. m. to see someone who was complaining. On the fourth floor he found an old lady who was "cutting up," as the nurse said. He examined her and found no obvious cause for her doing so, so he assumed that she was a neurotic and ordered a "sterile" hypodermic given. He then went back to bed quite pleased with himself. He had hardly fallen asleep when the nurse called him back to pronounce his patient dead. He received quite a shock, and the word "neurotic" had taken on a new meaning.

* * *

Case 2.—There was another lady on the fourth floor who was always complaining, and no one found an adequate cause. The internes and nurses treated her with restrained contempt. She got sterile hypodermics, bromids, and ammoniated tincture of valerian. Finally, someone sent her to the gynecological ward, when it was decided to open her abdomen. It was found that her belly was full of adhesions, the aftermath of an old operation. These were freed, and she made a wonderful recovery. She no longer complained. She was grateful and appreciative. She gained weight and became another woman.

COMMENT

Let us assume that the Freudians, or who you will, had psychoanalyzed this woman and found some evidences of sex in her which can be found in most anyone by enough search, just as one can find water with a "forked stick" most anywhere in Ohio. Suppose that they had talked to her, and

filled her full of their explanations or system of psychology, and had gotten her to "shut up" or to grin and bear it—would she have been cured? Then, may I ask, what are the criteria of cure, absence of symptoms? But the only way we can know of many nervous symptoms is by what the patient says and does. If he stops complaining and acts normally, we are prone to assume a cure; yet the underlying condition may be there just the same.

What of these so-called cures? Do they stay cured? At St. Anne De Beaupré one can see a pile of crutches and wheel chairs, wooden legs, and what not, twenty feet high. How many do you suppose would like to return for them? Do they have a follow-up system—a visiting nurse or social worker to see if the old man buys another cane? What of the epileptic who takes bromid and has no fits—is he cured? What of the neurasthenic who so orders his life that he gets nine hours' sleep and does not overwork. Is he cured or is he only "living within his means"? The eye doctor who cures epilepsy by correcting astigmatism or hyperopia may not have really changed the nervous system, and an impacted tooth might bring back the whole picture. This nervous defect may be beyond our reach—perhaps it is hereditary, and that eugenics is the only real cure for society. Perhaps the clinical picture of neurasthenia is merely the symptom-complex resulting from an insufficiently energized nervous system. We know little of nervous energy—what it is, and where and how it is generated. Its lack of quantity may be due to systemic poisoning, such as influenza or tuberculosis. It may be that it is expended faster than it is generated, as in overwork. It may be conditioned by some hereditary defect, for it is obvious that the flame of life burns brighter in some than in others. It may be that it is due to illness or improper feeding in infancy. Man is a suggestible animal as well as being an automatic machine; and nature often repairs damage while our attention is distracted by some hocus-pocus which is then deemed to be the cause of the cure.

There is gross structure which helps to determine the larger activities, such as intestinal and heart function; and there is microscopic structure, which is a factor in the function of muscle nerve and gland; and then there is ultra-microscopic chemical structure, which we think must determine chemical and physical change, heredity, memory, and psychological processes. Then, according to our definition, a neurosis being a nervous disorder minus a structural change, and if, as seems probable, there is no function without a structural basis, then we must arrive at a new definition of neurosis, or else abandon it for a more definite classification. Used in the light of knowledge, it may be permissible to differentiate between gross and evident lesions, and the ultra-microscopic kind. As it is, it covers a multitude of sins and is an excuse for impatience, which, by rights, should be directed toward medical ignorance rather than the patient. The very fact that they often end up with dealers in magic, hypnotism, and theology is evidence enough of that.

We are beginning to believe that we think and act the way we do because of our structure and environment, and that even our thoughts are the result of, rather than the cause of these things. Behavioristic psychology is making a worthy effort to redeem the study of human behavior from the swamps and morasses in which it finds itself after centuries of darkness. Let us hope that their studies will throw light upon this side of human ignorance. The whole thing resolves itself into a question of psychology. Is, or is not man an ever-growing and changing machine? I, for one, believe that this assumption is the more useful concept. We all admit that it does no good to either swear or pray over such machinery as a gas engine, but words are adequate stimuli for man, and here is where the joker comes in: to a limited extent minute structural change may be reversible.

Life is a form of motion, and its direction and velocity depend upon the form of the structure, the amount of energy generated within, and the external environment. These are three variables, and in diagnosing deviations from the normal especially so-called nervous troubles, one should consider each with extreme care.

139 North Tenth Street.

AN EPIDEMIOLOGICAL STUDY OF AN OUTBREAK OF SYPHILIS

By R. L. Kaufman, M.D.
Whittier

IN the great majority of instances the health officer doing epidemiological work in the venereal diseases is confronted with but one contact of an infectious case. Far too often does the individual affected in presenting himself for diagnosis and treatment "fail" to remember the name or address of the person to whom he or she was exposed. The statement is frequently volunteered that the exposure was to an individual who happened to be passing through town on his way East or North, or any other convenient direction. The physician administering the treatment in a health department clinic will find that to threaten or scold patients into revealing the identity of their infected partners will very often drive them away. It is much better to reason with them and explain the mode of spread of these infections, and to stress the point that their partners may even be unaware of being infected and deserve having medical check-up. The general public has the mistaken notion that the discovery of venereal disease is equivalent to loss of a job, as a punishment meted out by the health department. This fallacy also impairs complete identification of contacts. Very often, after an individual has visited the clinic or office a number of times, and has gained confidence in his doctor or nurse, he will give the name and address of the contact, or even arrange to have him or her come in for examination.

For every patient who presents himself to a health department or physician's office for antivenereal therapy, there are usually others infected from the same source who go elsewhere for treatment. And it is uncommon for more than one

Name	Age	Color	Marital Status	Week of Exposure	Appearance of Lesion	Appearance at Clinic	Darkfield	Wassermann
1. T. P.	42	White	Single	3-4-35	4-17-35	4-24-35	Negative 4-26-35 Negative 5-3-35	Negative 4-24-35 Negative 5-4-35 Four plus 5-15-35
2. H. P.	21	Mexican	Single	2-17-35	4-4-35	4-25-35	Not done. Had used ointment previously on lesion.	Four plus 4-25-35 Four plus 5-1-35
3. N. M.	40	White	Single	3-25-35	4-18-35	4-25-35	Positive 4-26-35	Negative 4-25-35 Negative 5-1-35 Negative 5-7-35 Negative 5-13-35
4. A. W.	28	White	Married	3-25-35	4-25-35	5-1-35	Negative 5-18-35	Negative 5-1-35 Negative 5-8-35 Three plus 5-15-35
5. A. S.	24	White	Single	4-8-35	4-25-35	5-2-35	Negative 5-2-35 Used local medication on lesion before coming to clinic.	Negative 5-2-35 Four plus 5-8-35 Four plus 5-15-35
6. W. G.	59	White	Single	4-8-35	5-16-35	5-23-35	Unable to go to clinic for darkfield because of finances.	Negative 5-23-35 Four plus 6-5-35 Four plus 6-11-35

victim to come to one office. Consequently, the following report on the transmission of syphilis by one woman to six men, all of whom came to the Whittier district office of the Los Angeles County Health Department, may be of interest from the epidemiological and sociological viewpoints.

These six men presented themselves to the health office within a period of five weeks; the first one on April 24, 1935, and the last one on May 23, 1935. Examination showed single or multiple penile lesions, subsequently proved to be hard chancres, and each one volunteered the name of one woman (name) of Whittier as being the one to whom he was exposed. From this point we will take our story back several weeks to April 5, 1935.

REPORT OF CASE

On this date (name) came to the office and wanted treatment for a generalized rash. As the health officer was out, the nurse sent her home and told her to remain in bed, promising that the health officer would visit her later in the day. A home call that day revealed a white woman, age forty-four years, a divorcée, living alone in a one-room flat in Whittier. Her complaint dated from March 31, 1935, when she developed fever, headache, and generalized aches and pains. On Tuesday, April 2, a generalized, raised, salmon-colored rash appeared, coinciding with an increase in her symptoms. On Thursday, April 4, her back began to ache and her eyes became suffused and reddened. This was the picture on April 5, when the writer examined her. The original impression of severe German measles in an adult had to give way to a suspicion of secondary lues, when a call on April 6 demonstrated an exacerbation of symptoms and a fever of 102 degrees Fahrenheit. A Wassermann taken that day returned four plus, and the patient was immediately sent by ambulance to the Los Angeles County General Hospital contagious ward, with the diagnosis of secondary lues. The source of her infection could not be determined, inasmuch as she had had more than one etiological possibility. At the hospital another blood Wassermann was taken, following which she was given three intravenous injections.

She was released from the hospital on May 1, 1935, although still in an infectious state, and returned to Whittier, where she came each week to the venereal disease clinic for therapy until she moved out of our jurisdiction. Treatment was refused her on May 15 because she appeared at the clinic in a very drunken state, barely able to walk straight. Upon being told that she was too ill to receive an injection, she became belligerent and threatened to go out and "infect every man in town," as she put it. However, no treatment was given in her state of alcoholic intoxication, but she appeared the very next day, somewhat more sober, and apologized for her previous day's actions.

Of the six men who named her, all are single, fortunately, except one. The first one appeared while (name) was in the General Hospital, on April 24, 1935. The accompanying table shows the sequence of events for each individual. The ages of these six men ranged from twenty-one to fifty-nine, the youngest being a Mexican. All of the chancres were accompanied by bilateral inguinal adenopathy of the discrete type, with some edema of the glans and foreskin. Therapy was not instituted in any case before laboratory confirmation by either darkfield or Wassermann had been obtained.

Thus far three blood Wassermanns on the wife of A. W. have returned negative. She has no lesions or symptoms and is still under our observation. She presents a typical example of the dangers innocent contacts undergo from irresponsible individuals.

In addition to these six infected individuals, another man, H. R., age twenty-three, was exposed to (name) the week of March 25. However, he had been under our care for syphilis since July 18, 1934, getting thirty-six treatments up to the time of this exposure. He used no prophylaxis of any sort, and did not develop any lesions.

All the chancres cleared up immediately following therapy, accompanied by cessation of associated symptoms. No other possible source of infection has thus far been ascertained in this series of cases.

SUMMARY

Aside from the physical, mental, and sociological damage done by this lone fountain of infection, the economic cost to the community is of some concern. If we can say that it costs approximately $300 to treat a case of syphilis to its conclusion, we reach a total of $1,800 for these cases as the price the taxpayer has to pay. And this sum represents only the cases that have come under our control. The actual cost, therefore, is probably higher.

IN CONCLUSION

A series of six cases of syphilis is presented because of the interest created by their all naming a common source of infection. A true understanding of our national venereal disease problem can be easily pictured from this distinct epidemic.

402 South Greenleaf Avenue.

GONORRHEA IN PREGNANCY

ITS TREATMENT AND RELATIONSHIP TO OPHTHALMIA NEONATORUM

By S. I. Movitt, M.D.
Los Angeles

CONSIDERING its prevalence and far-reaching influence on health and bodily resistance, gonorrhea in the female is of utmost importance; and during pregnancy its importance is far greater, since it affects not only the mother, but also the child. According to J. Johnston Abrahams,[1] 40 per cent of the sterility in women, 50 per cent of all gynecological operations, and 20 per cent of the total blindness of the world are the direct consequences of unsuccessfully treated gonococcal infection. It is important and fitting, therefore, that physicians should acquaint the public with the general and widespread evil effects of gonorrhea. Neisser at one time stated that, with the exception of measles, gonorrhea was the most widespread of all diseases. This may be an exaggeration; nevertheless, the disease is by no means rare.

Mode of Infection.—Except in the case of young children, where gonorrhea is transferred indirectly, it is transmitted almost exclusively by sexual intercourse. In rare instances it may be spread by towels, napkins, douche nozzles, or by an infected person. A frequent mode of infection is that of the wife by a husband who has had gonorrhea, but was supposedly cured. The most important characteristic of the gonococcus from the clinical viewpoint is its power of latency. The organism remains living in the human tissues, but is temporarily inactive; that is, the patient has gonorrhea, but presents no symptoms. The disease may remain latent and suddenly light up into active virulence because of local hyperemia—from excessive intercourse, menstruation, childbirth, or ill-advised pelvic operations. The latent germ may be aroused into acute activity in two ways: It may either produce a fresh gonorrheal attack in the individual in whom it has been residing as a latent parasite, or it may be transferred to another individual and, finding there a fresh soil more congenial to its growth, incite an acute process.

Gonorrhea and pregnancy may coexist under three conditions: (1) the gonorrheal infection may antedate the occurrence of impregnation; (2) the gonorrhea may have been acquired during coitus, which also resulted in conception; and (3) the gonorrhea may have been contracted after conception has occurred.

Most cases that one has to deal with belong to Group 1. The infection, having passed the acute stage, becomes chronic. The two other groups usually present the acute and subacute forms of the disease.

The influence of pregnancy upon a preëxisting gonorrhea is usually quite pronounced. The marked congestion of the tissues, incident to the gravid state, furnishes abundant stimulus for the multiplication of the gonococci, which thus causes an exacerbation of a latent gonorrhea. It seems that pregnancy predisposes to widespread upward extension, occasionally causing endometritis and deciduitis, and even involving the tubes. However, gonorrhea is not such an important causative factor in abortion as formerly supposed. A study of Bernstine and Castallo's[2] statistics, extended over a period of five years and including 3,586 deliveries at Jefferson Maternity Hospital, shows that eighty-four patients had *positive* finding for gonococci during pregnancy and received the following treatment, which was adapted to the stage of infection and was continued until the time of delivery. In acute gonorrhea, rest is most beneficial. After the symptoms gradually subside, a simple cleansing douche and sedative measures are all that is employed. Later a douche, containing one teaspoonful of Lugol's solution to two quarts of warm water, may be used. When the acute symptoms have entirely subsided, the patient is treated more vigorously along the same lines as chronic cases. The treatment of chronic cases is divided into two parts: those measures that the patient uses at home, and those that the physician carries out.

Home treatment consists of daily vaginal douches under low pressure, using one teaspoonful of Lugol's solution to two quarts of boiled water. The office or hospital treatment consists of exposing the cervix with a vaginal speculum. The discharge is carefully wiped away from the cervix. A pledget of cotton, saturated with aqueous solution of metaphen 1 : 1000, is placed in the cervical canal and left *in situ* for five minutes. The vagina is then swabbed with the metaphen solution; if there is urethral involvement, about fifteen drops of 10 per cent argyrol are instilled into the urethra.

Out of the above-mentioned 3,856 deliveries at Jefferson Maternity Hospital (Philadelphia), eighty-four cases were complicated by gonorrhea and treated for it during the prenatal period in the way outlined above.

The children born of mothers in the treated group were free from gonorrheal ophthalmia. The babies of both groups received exactly the same prophylactic eye treatment when delivered, yet there were fifteen cases of gonorrheal ophthalmia born of mothers who did not receive prenatal treatment (who apparently did not give evidence of gonorrhea, thus escaping treatment which they should have received).

This would show that the prenatal treatment of mothers afflicted with gonorrhea is a more important prophylactic measure against gonorrheal ophthalmia than Crede's prophylactic instillation of silver nitrate in the eyes of the new-born child.

1025 Story Building.

1 Abrahams, J. Johnston: Gonorrhea in Women and Children.

2 Bernstine and Castallo: Medical Record, p. 97 (Jan. 16), 1935.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

INTRA-ORAL LESIONS

I. ETIOLOGY

George V. Kulchar, M.D. (450 Sutter Street, San Francisco).—The oral mucous membrane and the skin are closely related. In many dermatoses, lesions also are present in the oral cavity. The etiology of lesions occurring within the mouth is varied and multiple, as in diseases of the skin. The cause in some instances has not as yet been determined. Bacterial virus, spirochetal and mycotic infections, dietary deficiencies, systemic and metabolic disorders, trauma, neoplasm, nevi, allergic and drug reactions, are the most commonly known causes.

The most common cutaneous diseases having oral manifestations are lupus erythematosus, lichen planus, pemphigus, and erythema multiforme. At times the oral lesions may be the only phenomena observed and may be present for weeks or months before the appearance of the cutaneous lesions. Oral lesions occasionally occur in dermatitis herpetiformis, keratosis follicularis, scleroderma, and acanthosis nigricans. Occasionally, impetigo, erysipelas, rhinoscleroma, lupus vulgaris, and leprosy may extend from the skin on to the oral mucous membrane. In exfoliative dermatitis, eczema, hydroa-estevale, mycosis fungoides, psoriasis, tinea corporis and zoster, intra-oral lesions are uncommon, but may be seen. Eruptions from various drugs may occur simultaneously on the skin and mucous membrane. These will be discussed later.

Infections due to bacteria of various types may occur in the mouth primarily, in addition to those secondarily extending from foci on the skin. Severe streptococcic infections rapidly extending down the faucial planes toward the pharynx may be seen (Ludwig's angina). Streptococcal impetigo may occur occasionally. Chancroidal infections due to streptobaccilus of Ducrey, either in association with genital lesions or alone, are at times seen. Gonococcal stomatitis, while rare, has been reported. Infectious stomatitis, the lesions resembling aphthae, may be produced by staphylococci or streptococci. Oral diphtheria, resulting from an extension of faucial infection, occasionally may occur. Likewise pseudodiphtheria infections, which can be diagnosed only by bacteriological examination, at times may be encountered. More rarely, infections, such as glanders and anthrax, may have oral manifestations. In addition to extension from facial focus, erysipelas may originate as a primary infection, usually beginning about the socket of a recently extracted tooth. Stomatitis, presumably due to infection, may be seen in influenza. The simultaneous occurrence of oral and vulvar lesions (ulcus acutum vulvum) caused by the bacillus crassus, is observed occasionally.

In addition to the extension of lupus vulgaris from the skin, tuberculosis may occur primarily within the oral cavity. Inoculation tuberculosis, the so-called tuberculous chancre with satellite lymphadenopathy, while uncommon, is occasionally seen. Infections may be from a focus elsewhere in the body or from external sources. In addition to a tuberculous chancre, fissures and papillomatous or ulcerative vegetative forms as the result of systemic tuberculosis are frequent. In addition to zoster, other virus diseases, such as herpes simplex and verrucae, are found in the mouth. The former is more commonly seen on the lips, although intra-oral lesions resembling aphthae or a generalized stomatitis are not uncommon. Systemic virus diseases, including the exanthem, may have oral manifestations.

Acute or chronic ulceromembranous gingivitis or stomatitis (Plaut-Vincent) are frequently seen. While fusiform bacilli and spirochetes can usually be found in the smears, whether these are the primary cause or secondary invaders, has not as yet been determined. Infestation of the fusospirillary group is not uncommon in other oral lesions. Gangrenous gingivitis and stomatitis (noma) are regarded by some as a severe form of acute ulcerative gingivitis, often following slight trauma or as a complication of debility, usually in children and the aged. In addition to fusiform bacilli and spirochetes, numerous other pathogenic organisms may be present. Gummatous nodules, occurring in the nasopharyngeal region, may be a late manifestation of yaws. Primary syphilis is a common cause of intra-oral lesions. The lesions may occur anywhere within the oral cavity, excepting the teeth. Secondary lesions may be seen in the oral mucosae, tonsils, or tongue. Destructive late lesions are common in the nasopharynx and tongue. In addition to gummatous infiltration of the tongue, a sclerous or interstitial glossitis may occur.

A variety of mycotic organisms may cause intra-oral lesions. The most common is mycotic stomatitis (thrush). From the lesions, Monilia albicans is most commonly recovered. Occasionally, other members of the same group are the cause. The etiology of black hairy tongue is variously reported. A streptothrix, which may play some part in its production, is at the present time the most accepted cause. Actinomycosis most frequently originates in the mouth and may be primary in the tongue. Coccidioidal and deep blastomycotic infections are rare, as is sporotrichosis.

Oral lesions are common in some of the exanthem, particularly varicelli, measles, scarlet fever and variola, and are frequently of aid in diagnosis. Ulcers and stomatitis are common in typhoid fever, while herpes is frequently seen in meningitis, malaria, and pneumonia.

Dietary deficiencies, particularly vitamins, may be followed by oral lesions. Erosive stomatitis, gingivitis, and glossitis are common in pellagra. Gingivitis and edema occur in beriberi. Hemorrhages from the gums are seen in scurvy.

In many systemic diseases oral manifestations are common. A stomatitis, characterized by dryness and a deep-red color of the mucous membrane, occurs at times in diabetics. A similar or an ulcerative stomatitis may be seen in uremia. The smooth, brightly erythematous tongue and papillary atrophy is part of the diagnostic picture in primary anemia. Hemorrhagic stomatitis, often with secondary invasion of the fusospirillary organisms, may occur in the leukemias. In agranulocytosis, gingivitis, stomatitis, or combinations of these, necrotic ulcers and gangrene about the tonsils, pharynx, palate, or tongue are common, from which the Klebs-Löffler bacillus, fusospirillary organisms, and a variety of other bacteria, have been isolated. Hypertrophic gingivitis occurs during pregnancy. Macroglossia may be found in acromegaly, in syphilis, and myxedema. Pigmentation of the oral mucosa is noted in Addison's disease, cirrhosis of the liver, hemachromatosis, and occasionally following melanotic tumors. Xanthomatous infiltrates and lesions may be seen intra-orally in the lipoidoses. Bluish-gray deposits of lead along the gingival margin are noted in lead poisoning.

Factitial lesions in the mouth are not uncommon. Traumatic ulcerations and anesthesias may be found in hysteria. Oral neuroses and phobias usually referred to the tongue are seen, the underlying mechanism generally being a cancer phobia.

Dermatitis venenata (contact dermatitis) may occur in the mouth, either as a result of irritants or sensitization from vulcanite in dental plates, mouth washes, tooth paste, etc., or on the lips, as a result of lipstick.

Drugs are a frequent cause of oral lesions, usually accompanied by a cutaneous eruption. It is impossible to enumerate all the drugs which may be the cause. The most common, however, are the acetanilid-antipyrin group, producing erythema multiforme-like lesions or angioneurotic edema of the mucosa. Similar eruptions, usually cyanotic in color, may be produced by phenolphthalein. Salicylates, including aspirin, may cause erythema, edema, and vesiculation. Bullous and vesicular lesions are seen after barbital and its derivatives. Bullous and hemorrhagic lesions from iodids and hypertrophic vegetating lesions from bromids may occur. Urticarial edema, erythema, and vesiculation may follow the use of quinin and its combinations. Severe gingivitis and stomatitis may be complications of the prolonged use of mercury. Similar stomatitis, with deposits of bismuth about the gingiva, tongue, and cheeks, is seen following bismuth therapy. A bluish-gray discoloration of the oral mucous membrane and tongue may be noted in generalized agyria, or in small patches following the prolonged local application of silver compounds.

As a result of chronic irritation of the mucous membrane and tongue, leukoplakia may develop. The etiology can be established in the great majority of cases. Trauma or chronic irritation from poorly fitting dentures, ill-shaped or malposed teeth, may be the cause. Ill-kept or poorly fitting plates, or prolonged chemical irritation, also may be factors. The relation of syphilis to leukoplakia is not established, although it is seen frequently on the oral mucous membrane at the site of secondary syphilides or on the tongue following late syphilis. Syphilis is also thought to be an indirect cause in some way predisposing the mucous membrane to leukoplakia.

Nevi are not uncommon in the oral cavity. Pigmented lesions are seen more frequently on the lip. Hemangiomata and lymphangioma likewise are often seen. Lesions of neurofibromatosis may occur in the mouth or on the tongue. Numerous benign new growths, such as papillomata, pyogenic granuloma, adenoma, lipomata, myxomata, myomata, and keloids, are frequent. Adenomatous hyperplasia of the mucous glands of the lip and buccal mucous membrane may be found (Fordyce's disease). Retention cysts of the mucous gland may occur, producing mucoceles. Epithelioma of the lip, buccal mucous membrane, or tongue, almost always of squamous-cell type, originating in areas of leukoplakia, is, of course, well known. Neoplasms of the gingiva, grouped under the general term of "epulis," may occur. Sarcoma is relatively rare in the mouth.

Urticaria, due to food or drugs, may be accompanied by angioneurotic edema of the lips, tongue, and palate.

The most common lesion occurring within the mouth is the aphthous ulcer, often multiple, the etiology of which is varied. Vitamin B deficiency is claimed by some to be the principal cause. The lesions appear sometimes to be allergic, due to foods or drugs. Digestive disturbances have been frequently observed accompanying aphthae, and are regarded by some as the cause. In many cases the etiology cannot be established. The virus of herpes simplex and staphylococci may produce lesions frequently mistaken for aphthae. Geographic tongue is another frequent condition in which the etiology is still obscure. While occasionally associated with organic disease and debility, it is frequently seen in healthy individuals and may be regarded as a constitutional neuropathic anomaly.

The multiple, varied, and often obscure etiology of intra-oral lesions makes necessary a thorough examination of the patient, utilizing all the laboratory facilities. Even with these measures, in some instances the etiology cannot be established.

* * *

II. SYMPTOMS AND DIAGNOSIS

H. P. Jacobson, M.D. (520 Westlake Professional Building, Los Angeles).—It is somewhat of a task to attempt a discussion of the diagnosis of oral pathology in the limited space at my disposal. The subject matter is extensive and fairly embraces in miniature the entire domain of general pathology. Like the cutaneous envelope, the oral mucosa may serve as a reflecting mirror and portray reactions to local insults, and, in greater

measure, the presence of systemic infection, intoxication, or other biological disturbances in distant parts of the body. Unlike the skin surface, however, the oral mucosa has not the protective advantages of the corneous and granular layers of the skin epidermis. The absence of these two epithelial layers, together with the peculiar environmental conditions of the oral cavity, such as increased temperature and moisture, render the mucous covering of the cavity not only more vulnerable to chemical, mechanical, and biological irritants, but also serve to modify the morphology of primary lesions to such an extent as to make their recognition and diagnosis more difficult.

In a general way, the different eruptions occurring within the oral cavity may, for purposes of definition and diagnosis, be divided into four major categories as follows:

1. *Lesions Due to Local Causes.*—Under this heading are included all oral lesions produced or caused by any and all physical, thermal, electrical, chemical, and biological agencies working locally, or *in situ*. As representative members of this group may be cited, for instance, the lingual fissures, erosions, and superficial ulcerations caused by jagged teeth, or by the epileptic bite. Also, the erythematous, purpuric, vesicular and bullous eruptions produced by chemical caustics (usually in attempted suicides), and those caused by exceptionally hot drinks, such as coffee, tea. etc. Here, too, may be included the leukoplakial-like lesions caused by electrical discharges of two different metals in dental fillings.

Important members of this category of eruptions are the different lesions produced by the local presence and activity of certain bacterial and fungous parasites. The morphology of these lesions varies considerably according to the type and virulence of the causative parasites, as well as according to the patient's immunity. On the one hand there are the fairly superficial vesicular and ulcerative lesions of aphthous stomatitis, which most authorities attribute to a staphylococcic organism. Again, we have the fairly superficial, somewhat infiltrated, ulcerative or fissured lesion of the primary stage of syphilis; also the somewhat deeper, rapidly spreading and more destructive ulcerative gingival lesions of trench mouth or acute ulcerative membranous gingivitis. This eruption is caused by a mixed infection represented by the fusiform bacillus acting in symbiosis with the Spirocheta dentium. The disorder belongs to the acute infectious destructive inflammatory diseases of the gingivae, usually starting at the buccal surface about one or more teeth and spreading rapidly. Here, too, belongs the well-known clinical entity of thrush, a membranous stomatitis and glossitis, caused by a yeastlike fungus, M. albicans, and usually occurring in the poorly nourished or the feeble—in the very young or very old.

A marked morphological variation of the above simple inflammatory, more or less superficial types of lesions are the deep-seated, tumor-like granulomatous masses caused respectively by the tubercle bacillus, Treponema pallidum, Actinomyces, and C. immitis.

2. *Sensitization Eruptions.*—Here one may include all intra-oral eruptions that are expressions of hypersensitivity to various kinds of food, drugs, medicaments, etc. The various foods or chemicals that may serve as sensitizing agents in certain individuals are legion, and different persons may be sensitive to different substances. A diagnostic characteristic of the primary eruptive elements that enter into the composition of these eruptions is their usually evanescent and superficial character, and their tendency to spontaneous involution upon the withdrawal of the sensitizing agent. The lesions may consist of erythematous macules or plaques, vesicles or bullae, or urticarial elements.

3. *Lesions Secondary to Systemic Infections and Intoxications.*—This group embraces all oral eruptions that are secondary to, or associated with systemic or cutaneous syndromes, as well as metallic intoxication—especially bismuth, mercury, gold, and the arsenicals. Representative members of this group are the vesicular or bullous lesions of erythema multiforme, dermatitis herpetiformis, pemphigus vulgaris, epidermolysis bullosa, acute disseminated lupus erythematosus, the hemorrhagic and erosive lesions of hemorrhagic sarcoma, and of some of the leukemias. Also, the variously sized and shaped plaques of psoriasis, lichen planus, chronic lupus erythematosus, and the classical leukoplakia.

4. *Neoplastic Growths of the Oral Cavity.*—This group includes all new growths, benign and malignant, and comprises the epithelial, endothelial, connective tissue, and the mixed tumors. Their gross appearance depends upon their histological structure and age, as well as upon the character and state of immunity of the patient.

Diagnosis.—Diagnostic differentiation of one eruption from another may, in occasional instances, be achieved by mere inspection of the primary component elements and examination of their morphological architecture. The characteristic cluster of vesicles situated upon or within erythematous and/or inflammatory areas of herpes simplex, or herpes zoster, characterized by varying degrees of pain (preceding, accompanying, or following the onset of the eruption) and, in the latter instance by a unilateral distribution after the course of a nerve; or the fairly pathognomonic fungating, ulcerating, infiltrating lesions of advanced carcinoma should offer no particular diagnostic difficulty to the experienced clinician.

For the most part, however, eruptions of the oral cavity do not lend themselves to easy recognition, but require clinical and, frequently, laboratory studies, and an evaluation of these in the light of associated existing pathology in other tissues and organs. A very essential preliminary to diagnosis is a pertinent case history. This need not consume much time or space, but should stress the mode of onset, duration, subjective symptoms, history of antecedent or associated diseases, including allergic disorders, and previous treatment. The question of drugs and chemicals—either applied locally (especially dentrifices) or taken internally as laxatives, sedatives, or tonics—should receive special attention in all history-taking, as these will

be found responsible for presenting oral eruptions rather frequently.

Important, too, is a good source of illumination. Diffused daylight is best for the purpose, but an electric flashlight or a small electric dental lamp may serve just as usefully.

With the oral cavity exposed to inspection in a good light, and with a pertinent history as a background, one may then proceed to study the morphology of the elements composing the eruption, and note especially their character (whether vesicular, macular, nodular, etc.), arrangement, configuration, color, and consistency. Information thus obtained frequently suffices to establish a clinical diagnosis, especially in early cases before environmental influences succeed in affecting secondary changes in the lesions. The fairly typical picture, for instance, presented by the geographic tongue, consisting of sharply defined, variously sized and shaped, smooth-surfaced, shiny plaques, usually limited to the dorsum of the tongue and arranged in "map-like" fashion; or the characteristically grooved surface of the grooved or scrotal tongue, with a median, fairly deep furrow, and radiating symmetrically placed parallel grooves resembling the ribs of a leaf, which when interpreted in the light of their clinical histories, should offer no particular difficulties in diagnosis.

If in spite of a careful history and an adequate oral examination, diagnostic difficulties should present themselves, one may often obtain additional helpful information from an examination of the cutaneous surface. The differentiation of sharply marginated, slightly elevated, irregularly sized and shaped, somewhat thickened grayish plaques of oral psoriasis from those of oral lichen planus, and both of these from leukoplakia, may be facilitated materially by an examination of the skin, and the discovery thereon of the typical, easily diagnosable lesions of the first two entities. The same may be said of the diagnostic difficulties surrounding the attempted differentiation of oral bullae of erythema multiforme from those of pemphigus vulgaris. An examination of the skin in these instances usually yields sufficient information to establish a correct diagnosis.

Now and then one meets with instances of oral pathology which, in spite of pertinent histories, adequate facilities for oral examination, and a thorough cutaneous inspection, require additional laboratory help for the establishment of a correct diagnosis. Limitation of space prevents a consideration of the many clinico-pathological entities and their differential, diagnostic characteristics that would come within the purview of this category. As representative members of this group may be mentioned the specific infectious granulomas, which comprise the tuberculomas, the nodular, fibrotic and/or gummatous tertiary syphilitic lesions, the actinomycotic and coccidioidal granulomas.

These granulomatous lesions may resemble each other grossly and microscopically fairly closely, but differ totally etiologically and in their response to different therapeutic procedures. A correct evaluation of these lesions, and their differentiation from some pyogenic granulomas, lingual amyloidosis, and the various benign and malignant neoplastic lesions (especially the epidermoid carcinomas), may require all the diagnostic procedures detailed above plus serological, bacteriological, mycological (microscopic and cultural), and tissue microscopic studies.

As guiding-posts to a clinical diagnosis it might be mentioned here that the tuberculous ulcerated granulomas are usually secondary to systemic tuberculosis, are more rapid in their evolution, softer, and much more tender and painful than are the tertiary lesions of syphilis, or actinomycosis. The actinomycotic tongue, for instance, has periods of exacerbations and remissions and increased local pain at the height of the former period. Coccidioidal granuloma of the oral cavity is rare, but when present is usually secondary to systemic coccidioides; the evolution of the lesions is fairly rapid and the pus is characteristically stringy, etc. The pyogenic granulomas are usually secondary to gingival or dental infections, which may be determined by x-ray and other studies.

The epidermoid carcinomas are commonly slower in their evolution than are the granulomas; they have a characteristic hard, infiltrating consistency, are fairly painless, and usually occur past middle life.

In brief, successful diagnosis of oral lesions depends upon knowledge of and ability to recognize distinguishing morphological characteristics of a given eruption. Some oral lesions lend themselves to clinical recognition and differentiation, while others may require laboratory investigations as aids in diagnosis. Viewing presenting eruptions in the light of group relationships, based upon related etiological factors, as suggested at the outset of this discussion, should prove helpful from the standpoint of orderly classification and should, therefore, facilitate differential diagnosis.

* * *

III. TREATMENT

H. J. Templeton, M.D. (3115 Webster Street, Oakland).—Whole books have been written dealing with diseases of the oral cavity. It is, therefore, obviously impossible to comment on more than a few of the fairly common mouth disorders in such a symposium as this.

Diseases of the mouth may be secondary to systemic disorders or may be purely local. If the former, they are treated primarily by controlling the systemic factor. If purely local, they are dealt with by appropriate local treatment plus, possibly, attention to the patient's general health.

The dry, reddish, parched mouth and tongue of the diabetic should be treated by diet or by insulin. The pale, buccal mucosa and the reddened, atrophic burning tongue of pernicious anemia will generally improve following the administration of the extrinsic and intrinsic anti-anemic extracts plus hydrochloric acid. The beefy-red mouth and tongue of pellagra can be combated with a well-balanced diet heavy in vitamin G (B2). Specifically, I order six cakes of yeast, a can of tomatoes, rare beef or liver, fresh vegetables, and milk daily. The several cases of leukemic stomatitis that I have seen have

been so fulminating that they yielded to nothing. However, in milder chronic leukemia the stomatitis should improve following Röntgen therapy directed to the general disease. Purpuric areas in the mouth disappear when the generalized purpura is controlled by appropriate transfusions, splenectomy, etc. A stomatitis from aplastic anemia, which I saw recently, recovered when the patient was repeatedly transfused. The intensely acute, swollen throat of agranulocytic angina will sometimes yield to repeated small transfusions or pentonucleotid. Of course, one should be certain to interdict the use of any drugs of the benzene ring series, especially amidopyrin and allurate. Scurvy, with its classical bluish-red swollen, bleeding interdental papillae will promptly disappear when vitamin C, in the form of orange or tomato juice or cevitamic acid, is given. It has been recently emphasized that subclinical scurvy is not infrequent. Hence it might be well to give an abundance of vitamin C in cases of swollen gums of obscure etiology.

The mouth lesions of syphilis, running the whole gamut from the chancre of the lip or tongue, on through the mucous patches of the secondary period up to the late gummas of the tongue or palate, literally melt away under the influence of the arsphenamins or bismuth plus iodids. Leukoplakia is sometimes caused by syphilis, so the first step in its management is a search for syphilis elsewhere. Unfortunately, even if syphilis is found, specific therapy does not influence the leukoplakia. The next step is to absolutely forbid the use of tobacco, because there is plenty of evidence that its use predisposes to the development and malignant degeneration of leukoplakia spots. Next, have the dentist get rid of all jagged teeth or snags. Next, observe the patches frequently. If they remain stationary, treatment is not demanded; but if they show any signs of erosion or fissuring, they must be destroyed at once with the actual cautery or electrodesiccation.

Tuberculosis of the mouth is practically always secondary to pulmonary or laryngeal tuberculosis, and responds very poorly to treatment. If the ulcers are small they can be destroyed with the actual cautery. The intense pain and dysphagia can be relieved, and the patient's nourishment facilitated by painting the ulcers with cocain or anesthesin before eating.

The lace-like reticular eruption on the buccal mucosae or tongue, which is the oral manifestation of lichen planus, does not yield to treatment and, since it produces no symptoms, should be left alone.

Extensive bullae and erosions of the oral cavity are seen in pemphigus, and practically invariably indicate early death. Treatment, save for local palliative measures, is hopeless. Similar bullae are also seen in the benign disorder erythema multiforme. The immediate attack yields to time, to calcium, and to autoblood injections, while recurrences can be prevented often by eliminating the causative factor whether it be food allergy, foci of infection, or drug ingestion.

Drugs may produce mouth lesions either following absorption from the gastro-intestinal tract or because of their local action on the mucous membranes of the mouth. Phenolphthalein laxatives, quinin, anacin, aspirin, etc., may cause mouth lesions. Several years ago, C. J. Lundsford and I reported a series of cases of stomatitis following the use of S. T. 37 toothpaste. Similarly, other mouth washes or dentrifices may produce local irritation.

"Burning tongue" is a distressing complaint of varied etiology. The Mayo Clinic, in analyzing a large series, found that a high percentage of cases was of unknown etiology or on a neurosis basis. Psychotherapy would seem to be in order. Sluder reported cures following removal of the lingual tonsils.

"Canker sores," in my opinion, are often precipitated by foods, particularly walnuts, to which the patient is sensitive. Scratch or intradermal tests have not helped in solving the problem; but by having the patient keep a food diary of all foods eaten during the twenty-four hours preceding a number of attacks, the physician often can locate the offender.

At the recent meeting of the American Medical Association, an exhibit demonstrated that many cases of stomatitis were due to food allergy and were controlled by elimination.

Fusospirillosis, or Vincent's disease, can be treated by having the patient rinse the mouth repeatedly with hot hydrogen peroxid solution. Once daily the physician should paint the areas with 5 per cent chromic acid in distilled water. After the acute phase has subsided a dentist should scale and clean the teeth.

Nonhealing fissures of the lip can be cured by freshening the edges with a scalpel and introducing a single suture.

Thrush in infants does well with one per cent gentian violet in acqueous solution.

Lastly, the disease of the mouth that interests me most, namely, cancer. In general, I prefer actual destruction of the lesion by means of electrocoagulation or the actual cautery, whenever the lesion is accessible to such treatment, to either x-ray or radium. However, there are cases in which the location of the lesion (for example, floor of mouth) or a poor condition of the patient causes radium seeds or needles to be preferred. The treatment must be individualized according to the demands of the case and the skill of the operator. Biopsies are essential. Cancer of the lip can be treated very successfully as an office procedure by means of electrocoagulation or cautery removal. If there are no palpable glands, they should be left alone. If glands can be felt, a thorough neck dissection or deep therapy is in order. Cancer of the tongue, in our experience, is best treated by wide destruction with electrocoagulation. In extensive cases, where a large part of the tongue has to be destroyed, it is safer to do a preliminary ligation of the blood supply. Small cancers of the floor of the mouth can be destroyed with electrocoagulation, but more extensive lesions are best treated with radium needle or seed implants.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

WILLIAM W. ROBLEE.....President
CHARLES A. DUKES.....President-Elect
LOWELL S. GOIN.....Speaker
KARL L. SCHAUPP.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *To the New Graduate.*
2. *Association Nights.*
3. *Ethical Advertisers.*
4. *Auxiliary.*
5. *Passing Comment.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Minutes of the Committee on Public Relations.*
2. *Minutes of Advisory Committee for Furnishing Care to Migratory Workers.*

TO THE NEW GRADUATE

To the graduate just entering practice—yes, to all engaged in practice—the reflecting upon the following is commended.

TRIBUTE TO THE MEDICAL PROFESSION

"Following the banquet of the Southeastern Surgical Congress, Dr. Irvin Abell, the president of the American Medical Association, presented the following:

" 'I know of no calling which offers such a wide diversity of intellectual pleasure as that of medicine, not alone in its art and science, with an ever-increasing range of new developments, but in human behavior, psychology, sociology, economics and related activities; we follow a most useful calling; an interesting occupation filled with new and striking problems and one of the best because its only aim is the benefit of man. Medicine is the most ancient of professions, being older than Christianity and antedating the inception of civil law. It has its own system of rewards and punishments, its own disappointments and its own glories. It is a profession that has a broadening influence on the human mind and is characterized by a most splendid charity. It is an acquisition in the best tendencies and a protection against the worst tendencies. It constructs no trusts; it founds no monopolies; it excludes no qualified practitioner; it retains for its profit no valuable discovery and it has no standing room for the quack, the scoundrel, and the charlatan. Its best work is not done in the light which beats upon the throne, not in the arena of politics encouraged by the cheers of thousands, not in the seclusion of the cloister sustained by the hope of eternal joy, but in the storm- and wind-swept country, in the strects of the village, in the boulevards of the city, on the desolate field of battle where pain and pestilence, illness and misery are combated often with none but God to see it. It furnishes a curiously checkered life, a life in which storm clouds alternate with sunbeams. With the exception of the ministry it stands closer than any other calling to the secret of eternity and watches death ever busy with her shuttle as she weaves her somber threads into the woof and warp of the affairs of men. It seeks to mitigate human suffering, to prolong human life. These have ever been its watchwords, are still, and always will be, constituting its cloud of smoke by day and its pillar of fire by night. One should enter such a profession with properly exalted ideals; with a belief in its greatness, its dignity, its stability, its real importance, its essential strength. One should resolve to learn to observe, to compare, to analyze, to study, to think, to avoid formulas, to cast out sordid thoughts, to repudiate shallowness, advertising, and vain pretensions. In short, to be a worthy disciple of Aesculapius, reflecting honor and credit on the profession and deriving from it the happiness that makes life worth while, being held in grateful remembrance by those whom one has served and in respect and esteem by the confrères with and among whom one has lived and worked.' "

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

ASSOCIATION NIGHTS

On April 12, President Morrow, Councilors Schaupp and Kelly, and Secretary Warnshuis discussed Association activities and problems before the monthly general meeting of the San Francisco County Medical Society. While the attendance was small, those present evidenced interest. It was regretted that a greater number did not embrace this opportunity to gain a more intimate insight to the functioning of their state organization that is their guardian.

On April 20, Councilors Phillips and Schaupp and Secretary Warnshuis appeared before a well-attended and actively interested meeting of the Santa Clara County Society in San Jose. This society is composed of 185 members, has its own quarters and library, issues a well-edited bulletin, and assumes an active rôle in community affairs. Its officers and committees accept, commendably, their respective responsibilities and retain the interest and support of their members. For these reasons Santa Clara County has an alert, progressive profession.

ETHICAL ADVERTISERS

This publication accepts advertising contracts from advertisers whose products are approved and conform to ethical standards. Advertisements for nonapproved products are not accepted. Members may, therefore, enter into business dealings with our advertisers with confidence. This assurance should be appreciated by members and, in turn, members should give preference to those advertisers who buy space in your official journal.

When detail men call upon you, inquire whether his firm advertises in your journal. You will save yourself much annoyance if you instruct your secretary or receptionist to make this inquiry and tell the detail man that you only grant interviews to representatives of firms who advertise in your journal.

There are firms whose products are unapproved, who seek space in county bulletins because they cannot obtain space in our state journal. In some instances they are successful in having their advertisement accepted. The suggestion is made that careful scrutiny be given to acceptance of copy for county bulletins. Ethical firms merit patronage. Please give it.

AUXILIARY

This comment proposes but one question to be answered by members and to be accorded consideration by county societies. It is quite a simple question: Why are women today, who apparently have so much power, using that power so little?

This is a direct challenge to Woman's Auxiliaries and counties without Auxiliary organizations. In the April *Courier,* the official organ of the Woman's Auxiliary to the California Medical Association, four avenues of activity and accomplishments were cited. The work and power of the members of the Woman's Auxiliary can cause those four activities to produce tremendous wholesome, constructive results for good in our state. Will Auxiliary members use their power?

PASSING COMMENT

It is often amusing to read the comments and inquiries in eastern publications whose authors are California medical men. Apparently, these correspondents fail to read this Association's official journal that published the information sought well in advance of the date when the inquiry was sent East.

* * *

June! That means vacations and the wide, open spaces, or at any rate a change of environment and relief from daily routine. Are you planning yours? You should.

* * *

"Our organized efforts and our conception of the profession's duty to the public has been, is, and always will be, an evolution. Our history is an ever-unfolding scroll of development, expansion, progress. To this altar of medicine with its changing, evolving service, we bring our dreams, our hopes, our fears, our ambitions, our studied visions, and plans for the future. We are confronted with numerous opportunities for service, dedicated to detract from physical pain and infirmities and to add to the joy and efficiency of individual lives. To that end every physician must dedicate his life. What greater privilege is there than to be a respected member of the organized profession of medicine?"

* * *

You toss your money away when you pay for listing or a card in the so-called special directories. These special directories are published solely for the profit of the promoter. The Directory of the American Medical Association is the only dependable directory consulted by insurance and industrial concerns. Your name is listed in that official directory without charge to you. Why fall for flattery, rosy promises, and misuse of your money? Buy a fishing pole or a mashie instead.

* * *

You do well to protect your patients and their children against typhoid and smallpox, also diphtheria, ere they set out for vacationland or other points for their annual outing. They will appreciate your advice and suggestions that they employ these preventive means.

* * *

Many medical men, with years of active practice experience, continue to wonder as to why this harangue, discussions, declarations, and hubbub about 30 to 60 per cent of the people not having adequate medical care. They are of the opinion that if more thought, effort and consideration were given to more adequate shelter, more adequate clothing, more adequate food, more adequate education, and more adequate employment, then adequate medical care would not be a problem.

Underfed, undersheltered, underclothed, and unemployment are basic factors that demand first consideration. When these needs become adequate there then arises the needs of more adequate education and intelligence in order that people will seek and obtain the adequate medical care that is already available but which, because of ignorance, is not sought and not employed.

Economists and propagandists might better concern themselves with the supplying of these basic needs of peoples before devising ill-advised plans for medical care that can never be made adequate when individuals and families are deprived of adequate food, fuel, clothing, and shelter. Is the reason possibly that the spoils from bureaucratic systems providing medical care are greater and more lucrative than those obtainable in providing basic needs of peoples? One wonders, and will continue to wonder until these facts are clarified. If more employment, better food, adequate shelter and clothing, and adequate education fails to better health welfare, then the medical profession will fill any need there may be for medical care.

The following may apply to those who seek to tell medicine that it is an obstructionist: "The householder was awakened by someone trying to fit a key into the front door of his house. Looking out the window, he saw that it was his neighbor, about three sheets in the wind."

"Go away, you fool," cried the householder. "You are trying to get into the wrong house."

"Shay," mumbled the neighbor, "whaddaya mean, wrong house? You're looking out of the wrong window."

Points of vision do alter opinions.

* * *

We encourage members to send their inquiries to their central office. When in San Francisco a cordial invitation to call is extended. Your central office desires to be most helpful and render every possible service to all members.

* * *

Conversation anywhere: "So your insurance company and you settled that suit for blank dollars?" "Yes, there was no merit to it and I didn't want the publicity, and the company felt that settlement could be made cheaper than cost of trial." Conversation at neighborhood bridge club three days later: "Mary, why are you late?" Mary: "I had to see Doctor Blank about Mother." First Party: "Oh, you have Doctor Blank? Did you hear that he settled that suit Mrs. Doe brought against him for blank dollars? He must have made a terrible mistake if he paid that much and settled out of court. I would be afraid to have my mother under his care." Next day (Mary phoning to Doctor Blank): "Doctor, I guess you need not call to see Mother."

Moral: Publicity of a suit is far less damaging to your practice than settlement.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

COMMITTEE ON PUBLIC RELATIONS OF THE CALIFORNIA MEDICAL ASSOCIATION MINUTES

Held in the offices of the Association, Room 2004, 450 Sutter Street, San Francisco, Saturday, April 23, 1938, at 9:30 a. m.

1. **Call to Order.**—The meeting was called to order by the chairman, Charles A. Dukes, with the following members present: President Howard Morrow; Fred B. Clarke, Committee on Health and Public Instruction; Daniel Crosby, Committee on Hospitals, Dispensaries and Clinics; Morton R. Gibbons, Committee on Industrial Practice; John H. Graves, Committee on Medical Economics; Junius B. Harris, Committee on Public Policy and Legislation; Frederick C. Warnshuis, Secretary.

Absent: Doctors Askey, Ruddock, and Roblee.

2. **Fee Schedule for Department of Employment.**—The Secretary presented a letter from the Department of Employment, State of California, asking that a fee schedule be provided for use in medical examinations in connection with hearings before the Department, which had been considered by the Council and referred to the Committee on Public Relations for action.

It was moved by Morton Gibbons, seconded by Daniel Crosby, that the Secretary advise the Department of Employment that the preparation of a fee schedule for use in hearings before the Board was being studied and would be considered during the annual session in May and that in the meantime additional data and definite circumstances be presented by the Board in order that full information may be on hand for consideration. Carried.

3. **Intercoast Hospitalization Insurance Association.** The Secretary read a letter from the Pacific Roentgen Club calling attention to the fact that the policy of the Intercoast Hospitalization Insurance Association had not yet been revised to agree with the principles laid down by the Association; and that an objectionable phrase was con-

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

tained in the literature disseminated to the public by the Association Hospital Service of Southern California.

It was moved by Morton Gibbons, seconded by Daniel Crosby, that the Secretary write to the Intercoast Hospitalization Insurance Association requesting that the wording of their policy be changed to conform to the interpretation laid down by the California Medical Association in regard to x-ray services. Carried.

Dr. L. H. Garland, Secretary of the Pacific Roentgen Club, was granted the privilege of the floor and explained the features objected to by his organization.

It was moved by Daniel Crosby, seconded by Fred B. Clarke, that the Secretary be instructed to write a letter to Mr. Heerman calling his attention to the objectionable matter in the folders being distributed by the Associated Hospitals of Southern California and that he be requested to make corrections in the copy and furnish this Association with the draft of the corrected copy. Carried.

4. **United Hospital Service.**—A request from the United Hospital Service of the Physicians' Life Insurance Company for approval of its policy was presented, having been referred to the Committee by the Council. The Secretary reported that additional data had been requested, but to the present date had not been received. Available data being insufficient to justify recommendation, action was deferred.

5. **Standard Oil Company.**—Messrs. Monasch, Holman and Scott, representatives of the employees of the Standard Oil Company, appeared before the committee on behalf of the suggested plan for indemnity against hospital, medical and surgical expenses incurred by reason of nonoccupational accidents and illnesses for the employees of the Standard Oil Company of California.

The Secretary read excerpts from the outline of the plan giving fee schedule and coverage and provisions.

Mr. Monasch explained that the plan contemplated the division of employees into three groups according to income and included three different premiums and three different fee schedules; provided for free choice of physician and hospital; and that at the present time the employees were considering carrying on the plan (1) by reinsurance in an established insurance company; (2) by self-insurance administered by employees; (3) by using service of medical groups.

After consideration, it was moved by Morton Gibbons, seconded by Daniel Crosby, that a committee be appointed to go over the plan and work out a fee schedule and offer other suggestions and report at the Pasadena session, and that the committee be authorized to appoint an advisory committee and consult with recognized men in the various fields of medicine. Carried.

The committee appointed consisted of Doctors Gibbons, Crosby, Clarke, and Warnshuis.

6. **Health Service System of San Francisco.**—The Secretary reported that all activity in regard to the plan of the employees of the city of San Francisco for furnishing medical and hospital care through the Health Service System of San Francisco was being held up pending the decision of the Supreme Court.

It was moved by Morton Gibbons, seconded by Howard Morrow, that further consideration be deferred until such time as the plan becomes operative. Carried.

7. **American Medical Association Survey.**—The difficulties encountered in carrying on the survey proposed by the American Medical Association were discussed, and it was suggested that further consideration be given the matter at the time of the Pasadena session.

8. **Industrial Practice.**—The Secretary stated that various inquiries and correspondence had been received in regard to certain practices carried on by insurance companies in industrial practice.

It was the sense of the committee that the entire situation be inquired into and that facts be secured from physicians who have cited specific instances, and later a conference with carriers, insurance commissioners, and other interested parties be held.

It was moved by Morton Gibbons, seconded by Fred Clarke, that a special committee be appointed to lay the groundwork for such conference, that available information be secured and that the conference be held prior to the American Medical Association meeting in San Francisco. Carried.

The committee appointed consisted of Doctors Gibbons, Crosby, Clarke, and Warnshuis.

9. **Adjournment.**—There being no further business to come before the committee the meeting adjourned.

CHARLES A. DUKES, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

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ADVISORY COMMITTEE FOR FURNISHING CARE TO MIGRATORY WORKERS*

Minutes of Meeting Held on April 24, 1938

At the Council Meeting, February 26, President Howard Morrow brought to the attention of the Council a request from the Farm Security Administration for coöperation of the Medical Association in the care of the migratory farm worker of California.

He stated that the Farm Security Administration expected to secure funds to provide medical care for this group, and the local administrator desired to give care to these people through the already existing channels, that is, through the general practitioner of medicine, through existing hospitals, and other facilities for the care of the sick.

The Council approved the appointment of an Advisory Committee, which was to consist of Past President Edward Pallette; A. E. Larsen, local Medical Director of State Relief Administration; W. R. P. Clark, representing the State Board of Public Health; and Karl L. Schaupp, representing the California Medical Association.

At a meeting of local members of the Advisory Committee with the officers of the Farm Security Administration at the office of the State Board of Public Health, a corporation, which is known as Agricultural Workers' Health and Medical Association, was formed under California law. Seven directors were selected for the purpose of providing medical care to the migratory agricultural worker. The seven directors are: Jonathan Garst, Regional Director of Farm Security Administration; Omer Mills, Robert J. Graves, and R. W. Hollinberg, representing the Farm Security Administration; W. R. P. Clark, M. D., representing the State Board of Public Health; A. E. Larsen, M. D., representing the State Relief Administration; and Karl L. Schaupp, M. D., representing the California Medical Association.

This Association then secured a grant of $100,000 from the Federal Government for the purpose described above.

It was the attitude of the federal members of this Board that the medical care of the migratory worker should be directed mainly by the medical members of the Board and that the provision of funds, accounting, and financial responsibility have to lie with representatives of the Farm Security Administration, and following this procedure a tentative plan has been developed which the Board feels should be subject to modifications according to the experiences and development in its earlier operation.

At the ~~February~~ April 2 meeting of the Executive Committee, Dr. Karl L. Schaupp was authorized to act for the California Medical Association on this Board. At the request of President Morrow a meeting was called of representatives from the following twenty counties in California: Imperial, Kern, Tulare, Kings, Fresno, Madera, Merced, Stanislaus, San Joaquin, Sacramento, Santa Barbara, San Luis Obispo, Monterey, Santa Clara, Sutter, Yuba, Yolo, Solano, Riverside, and Butte.

On Sunday, April 24, 1938, the following representatives from these counties met at the Sir Francis Drake Hotel for the purpose of hearing the plan as developed to this point and to make suggestions and criticisms, and to help in any manner possible the further development of a successful plan: L. R. Nielson, Fresno; John W. Green Solano; G. H. Rohrbacher, San Joaquin; William A. Clarke, Imperial; Karl F. Weiss, Tulare; Denver D. Roos, Riverside; Ed. D. Anderson, San Luis Obispo; L. P. Davlin, Monterey; Charles A. Preuss, Santa Barbara; H. A. Randel, Fresno; Hoyt R. Gant, Stanislaus; C. S. Compton, Kern; W. J. Blevins, Jr., Yolo-Colusa-Glenn; W. J. Van Den Berg, Sacramento; J. W. Linstrum, Yuba-Sutter; C. S. Compton, Kern; Elmo R. Zumwalt, Tulare; Leslie B. Magoon, Santa Clara.

* For editorial comment, see page 397. For press items, see page 476.

Also present were: Jonathan Garst, Howard Hill, Karl L. Schaupp, M. D., Richard Lyons, and A. E. Larsen, M. D.

At the meeting the procedure developed to date was explained as follows to the members present:

There shall be thorough social service investigation to determine whether or not applicants for care are actually migratory farm workers and that they have not sufficient funds for their own medical care. When their eligibility has been determined they may choose a local physician or may be referred to one if they have no choice, for the purpose of medical care. After his visit and report on a simple form, the physician may be authorized to proceed with further care. This form is then returned to the regional office and the physician will be promptly paid for the said service. It is hoped that the payment shall not be delayed beyond two weeks from the rendering of the first service.

The compensation for service at the present time will be under the fee schedule, for the basis is $2 for the first office visit, and $1.25 subsequently; $2.50 for the first home visit, and $1.75 subsequently. At the present time, a mileage rate of five cents per mile has been suggested. The present fee schedule is not finally adopted, and is open for changes that may be shown to be necessary by the experiences of the operation of this plan.

Hospital services will be rendered where nccessary preferably through existing private institutions. Payment for these services will be made through the Association at what shall be determined as a reasonable charge for patients of this class at conferences between the director and the hospitals.

It is the intention of the directors of this Association that so far as possible there shall be a free choice of physicians and a free choice of hospital by physicians and patient.

Your representative on this Board feels that the set-up at the present time is not complete nor is it adequate, and can only express to you this hope that the experience of the county societies involved will bring constructive criticism and suggestions which will develop this plan into a sound one for the purposes for which it is formed.

It is well to remember that this is the first time in California when an effort has been made to care for this class of patients with the coöperation of the California Medical Association. May I, therefore, ask that all your comments or criticisms be directed to Frederick C. Warnshuis, Secretary of the California Medical Association, 450 Sutter Strcet, San Francisco, who will refer such suggestions and criticisms to the Medical Advisory Committee.

Karl L. Schaupp, M. D.

COMPONENT COUNTY MEDICAL SOCIETIES

KERN COUNTY

The Kern County Medical Society met at the Mercy Hospital in Bakersfield on Thursday evening, April 21.

Dr. A. Stampar of Yugoslavia, associated with public health work of the League of Nations, was introduced by Dr. Charles E. Smith of Stanford Medical School. Doctor Stampar spoke informally of his experiences as a public heath pioneer in Yugoslavia and in China. During his two-day stay in Kern County, Doctor Stampar studied rural health conditions, especially in the migratory labor camps.

The speaker of the evening was Dr. L. H. Garland of San Francisco, whose subject was *The Medico-Legal Aspects of Roentgenology*. An important point in his talk concerned the proper designation of x-ray examinations as roentgenograms and not as "pictures." He demonstrated common and uncommon errors of interpretation of roentgenograms by means of slides.

Dr. L. A. Packard commented on malpractice insurance policies issued by Lloyd's underwriters.

On the evening of May 4 members of the Society met at a dinner meeting at the El Tejon Hotel, with Dr. Udo Wile of the University of Michigan as guest of honor and speaker. Doctor Wile gave an informative talk on *The Treatment of Early and Prenatal Syphilis*. Many questions were asked by those present about points of doubt in diagnosis and treatment.

C. S. Compton, *Secretary*.

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Dave Dozier, on Tuesday, April 19, at the Auditorium on Twenty-ninth and L streets.

A speaker from the Chamber of Commerce asked for the support of the medical profession in backing the coming Forty-niner program.

The speaker of the evening, Francis Scott Smyth, Professor of Pediatrics at the University of California Medical School, was introduced. The subject was the *Care of the Juvenile Diabetic*. The paper was very well presented, and elicited discussion and questions from Doctors Babcock, Sevier, Gourse, Scatena, Reardan, and Hilding Johnson.

Under new business, Doctor Dozier discussed the medical survey being undertaken by the American Medical Association. The following members were appointed to act as a committee locally: Drs. W. Pollock (chairman), Wallerius, Soutar, O. Johnson, and L. Farrell.

G. E. Millar, *Secretary*.

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SAN BERNARDINO COUNTY

The special meeting of the San Bernardino County Medical Society was held before the evening session of the Tri-County Postgraduate Conference on Thursday, April 7. About eighty-five members and guests attended the afternoon session of the Conference, and one hundred fifty members and guests were present for the evening meeting.

The meeting was called to order by the president, Dr. Delbert B. Williams, at 7:30 p. m. Doctor Williams explained that the meeting was necessary to bring before the Society the recommendations for the conduct of the Venereal Clinic made by the Committee on Public Relations and Public Policy, and the Advisory Committee to the County Health Officer. The recommendations had been accepted by the Council, but the Council felt that the Society as a whole should have the final vote in such an important matter.

The Secretary then read the report of these committees as follows:

1. That social service in the venereal clinic be on the same basis as now in practice at the County Charity Hospital except that: (*a*) Initial diagnosis to be free to everyone applying to the clinic for the first time (Social Service record to be made at this first visit and status for future visits, if necessary, determined). (*b*) County residence requirement waived, according to the federal plan; and, furthermore, that all existing information of other Social Service agencies be made use of when necessary.

2. It was further recommended by a motion that a minimum fee be set at $1.50 per treatment (drugs to be furnished by the clinic and accurate records of their use be kept by the physician). Also follow-up laboratory work to be done by the clinic if desired.

To further explain the purpose of this fee, the following is the feeling of the committee: That the meaning of this minimum fee of $1.50 is in no way to be construed to dictate the price a physician must charge, since this is the physician's right in dealing with his patient to set the fee, either higher or lower, as the physician sees fit, by the patient's ability to pay and is mutually agreed upon, but is set only as a basis or "yardstick" to guide the Social Service investigator in her judgment to segregate the purely clinic or free cases from the part-pay patients who are to be referred to the private physician for treatment. And that the patient is not to be told the amount of a fee to be charged by the private physician, as this is a matter to be settled mutually between the doctor and the patient in the usual manner.

It is also to be pointed out that the law provides that those infected patients forced to take treatment who refuse to pay, must be treated by the clinic free of charge, regardless of their ability to pay.

In the matter of consultants for the clinic the committee recommends that the present clinical staff of the San Bernardino County Charity Hospital be made consultants to the Venereal Clinic, with the same classification, rank and capacity as obtains in the Hospital, and that only members of the Hospital staff, having been duly elected to the staff in the usual manner of procedure required for appoint-

ment to the staff, are eligible to serve as consultants to the Venereal Clinic.

The variations and complications of venereal disease prompted the committee to make this recommendation as the only solution to an adequate consultation staff.

The County Health Officer will be the direct head of the clinic's full-time staff.

It was also further recommended that the Interne Committee of the County Hospital so arrange the interne service to include some time for service by internes in the Venereal Clinic so that they will receive this important part of their training.

It was generally conceded that further details and problems would have to be considered at a later date, as time, information, and experience will unfold.

Doctor Hilliard asked what provision had been made for referring patients to physicians. There will be a panel made up of the names of physicians willing to do the work, and that patients will be sent to them in rotation when the patient has no choice of physician.

After some discussion it was moved and seconded that the Society accept the report of the committee.

* * *

The regular meeting of the San Bernardino County Medical Society was held at the Loma Linda Sanitarium on Tuesday, May 3.

Dinner was served at 7:30 p. m. in the main dining room of the Sanitarium.

Members of the Riverside and San Bernardino County Medical Societies attended as guests of the medical staff of the hospital.

Eighty members and guests were present for dinner, and 150 were present for the program that followed.

The meeting was called to order by the president, Dr. Delbert B. Williams, at 8:30 p. m.

It was moved and seconded that the applications for membership would be voted on as a group rather than individually. The following applications were approved: Nile I. Reeves, Carrol S. Small, Milo O. Schroeder, Loma Linda; J. Needham Martin, Colton; Russell E. Atkinson, San Bernardino.

The program of the evening was as follows:

Practical Aspects of Vitamin Therapy: A Review of the Latest Developments in Vitamin Research—Henry Borsook, M.D., Ph.D., Professor of Biochemistry, California Institute of Technology.

The President, on behalf of the Society, thanked the medical staff for a profitable and enjoyable evening.

ARTHUR E. VARDEN, *Secretary.*

SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held on May 5 at the Hotel Wolf. The meeting was called to order by the president A. C. Boehmer, at 7:30 p. m. We had as our guest speaker, Dr. Udo J. Wile of Ann Arbor, Michigan, whose paper was on *The Management of Early and Prenatal Syphilis as They Relate to Public Health Control.* We had as guests, members from the surrounding counties. Doctor Wile's paper was illustrated by lantern slides, and caused considerable discussion from the floor.

Dr. Eugene Gay's application for membership in the San Joaquin County Medical Society being acted on favorably by the Admissions Committee, he was declared elected to membership.

G. H. ROHRBACHER, *Secretary.*

SAN MATEO COUNTY

The meeting of the Board of Directors of the San Mateo County Medical Society was held in the Library of Mills Memorial Hospital on Friday, April 15.

The applications of Drs. Thomas E. Bivins and Norman C: Fox were presented to the Board for vote. Both applicants were unanimously elected to membership in the Society. The application of Dr. W. C. Lynch was presented to the Board without official clearance from the State Association offices. The Board unanimously elected Doctor Lynch to membership, pending official approval from the state offices.

The Secretary announced that the dues of all members had been paid and that the Society now had a membership of seventy.

The Secretary requested that in view of the increasing amount of work connected with Society business coincident with its increase in size, certain work be allocated to committees which would carry out their duties to completion without throwing the bulk of committee work on the office of the Secretary. A motion was made, and unanimously carried, that where any committee failed to render a report in connection with work requested of the committee within a reasonable period of time that a new committee would be appointed to increase the efficiency of the administrative duties connected with the Society.

A letter from the Cancer Commission of the California Medical Association approving the program of the Women's Field Army was read. The matter was to be referred to the Cancer Committee of the Society with the request that it coöperate with the local branch of the Women's Field Army.

The Secretary made an announcement concerning the present status of the investigation now being carried out. It was felt that in view of the seriousness of the evidence accumulated by State Narcotic officials, the Board, at an early meeting, should act upon a complaint filed against this member. This action would take the form of preferring formal charges against this member.

In connection with disciplinary procedure, the Secretary made a report on the action recently adopted by the Los Angeles County Medical Society whereby in any disciplinary procedure a complaint is submitted to the Committee on Professional Conduct which, in this county society is the Board of Directors, and that following the filing of this complaint the Board either disposes of the complaint as unwarranted or prefers formal charges signed by the Board members acting as a Committee on Professional Conduct. This report was submitted by the Secretary with the feeling that it removed the personal element from the filing of charges against a member. A motion was made, seconded and carried, to approve the report of the Secretary and adopt the same as a policy to be followed in future disciplinary action. A copy of this report is attached to the minutes of this meeting.

* * *

The San Mateo County Medical Society met in the Staff Room at Mills Memorial Hospital on Wednesday evening, April 20.

Dr. Carl Hoag read an interesting paper entitled *Obstruction Following Gastro-enterostomy and Gastric Resection: A New and Simple Operation for Its Relief.* The paper was discussed by Dr. Kirk Prindle and Dr. Franz Gehrels.

Dr. John B. DeC. M. Saunders of the University of California Medical School closed the discussion. The paper was enthusiastically received by a large audience.

* * *

The regular April meeting of the San Mateo County Medical Society was held jointly with the Medical Society of the Veterans' Administration Facility in Palo Alto on Wednesday evening, April 27.

Following dinner in the nurses' home, a symposium on the *Neuropsychiatric Aspects of Syphilitic Meningoencephalitis* was presented by members of the staff. Dr. Chester M. Carlisle, President of the Medical Society, presented several interesting cases.

* * *

The Board of Directors of the San Mateo County Medical Society met in the library of Mills Memorial Hospital on Friday, May 6.

The following applicants were elected to membership: Dr. Werner Glaser of San Bruno and Dr. Leslie J. Seeley of San Carlos.

The Secretary read a letter from the Judicial Council of the American Medical Association in which a request was made that component county societies base disciplinary action against members only upon violations of the consti-

tution or by-laws or of the principles of medical ethics of the American Medical Association, and not upon rules of conduct or resolutions adopted at some particular meeting. The Secretary was directed to draw up a resolution calling for an amendment to the by-laws of the county society to clarify this point.

The Secretary announced that the Woman's Auxiliary to the San Mateo County Medical Society desired to have a joint meeting with the Society in May. The Board approved such a meeting for May 25, the Woman's Auxiliary to prepare the program.

A report from Dr. William F. Murphy, concerning the Committee on Public Health recently formed by Doctor Gans, County Director of Public Health, and the work of the Subcommittee on Consolidation of Health Units, was presented. The subcommittee recommended consolidation of all health units, including the school nurses, by one of the following two methods: (1) The voluntary turning over of all health units to the county department as provided for by the county charter. (2) The creation of a health district somewhat on the lines of that operated in San Joaquin County. The Board approved the action of the committee and recommended that consolidation might be better carried out according to the first method of approach under the county charter.

The Secretary read a summary of the work so far accomplished by the Medical Survey Committee and made a request of the Board for funds to continue this survey. A motion was made, seconded, and unanimously carried, that the Committee on Medical Survey should employ such funds of the county society as would be necessary to complete the survey. J. Garwood Bridgman, Secretary.

STANISLAUS COUNTY

The regular monthly meeting of the Stanislaus County Medical Society was held on May 10 at the Hotel Modesto.

Dr. Joseph Azevedo demonstrated a form of advertisement in the telephone directory of a certain county medical society in defense of that society against nonmembers. After considerable discussion the Society thought it best not to have any such form of advertising in our local directory.

Mr. Lyon, field director for the Agriculture Workers' Health and Medical Association, completely outlined this program and answered questions. There followed a long discussion, main opposition to the program being by Doctors Morris and Cooper. Finally, it was moved by Doctor Collins, seconded by Doctor Porter, that the program be tolerated as one of charity with the payment to be considered as expense money rather than money for service.

It was moved by Doctor Cooper that doctors doing lodge work contrary to a measure recently passed be reprimanded. If such doctors are not willing to coöperate, that they lose their membership in the Society and the right to use local hospitals. This measure was seconded and passed. It was also suggested by Doctor Cooper that there be no consultation of members in good standing with nonmembers.

Finally, Dr. F. Harold Downing of Fresno gave an interesting talk on *Pitfalls of the Treatment of Fractures.*

Hoyt R. Gant, *Secretary.*

TULARE COUNTY

A regular meeting of the Tulare County Medical Society was held on April 24 in Porterville at Taylor's Café.

Dr. Phil Barber, Vice-President, presided in the absence of Doctor Zumwalt, who was representing this Society at the Council meeting in San Francisco.

Dr. James F. Rinehart of the Department of Pathology at the University of California, was the guest speaker of the evening and spoke on *Differential Diagnosis and Etiologic Factors in Arthritis.* The talk was illustrated by lantern slides.

Dr. I. H. Betts reported on the University of California postgraduate course, which presented a symposium on the digestive system.

Dr. Karl Weiss reviewed a series of normal x-ray findings by lantern-slide projection.

Karl F. Weiss, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (54)

Alameda County

Joseph B. Reis

Butte County

W. D. Holt — Henry Mello

Humboldt County

Morris Krutchkoff

Imperial County

Charles M. Cutshaw — Frederick G. ReBell

Lassen-Plumas-Modoc County

Ernest F. Gianotti

Los Angeles County

Harry H. Alexander
Hugh C. Althouse
E. W. Barton, Jr.
Virgil L. Cameron
Frank Cole
Kenneth W. Eikenberry
John A. Gocke
J. Thomas Hardesty
Charles Keltz
Jean G. Kinney
Edward Levin
Joseph Lafe Ludwig
Donald O. McGowan
Henry A. McPherson
Irving G. Rosenberg
Charles M. Taylor
Harry O. Beach

Marin County

Alfred J. Schwartz — John C. W. Taylor

Orange County

John A. Larson

San Francisco County

George S. Campion
William Paul Gilbert
Benjamin J. Hagan
Pinckney Harral
Myer J. Heppner
Edward Ferris Holbrook
Vincent Johanson
Thomas G. Lawler
Gregory N. Maximov
Ferrall H. Moore
Kathleen M. Murphy
Samuel M. O'Connor
Percy Perry Poliak
Max L. Polse
Ellsworth F. Quinlan
Dorothy G. Sproul
Robert A. Stewart
Henry B. Woo

San Joaquin County

Eugene Gay

San Mateo County

Thomas E. Bivins
Norman C. Fox
Leslie J. Seeley

Santa Clara County

Leland B. Blanchard — Leland A. Childers

Santa Cruz County

Anthony E. Allegrini
Asher D. Havenhill
Philip Edward Karleen

Transferred (6)

Carl G. Gans, from Los Angeles County to Arizona.

William Harding, from Sacramento County to Marin County.

B. W. Knopf, from Contra Costa County to Alameda County.

Fred B. Moor, from San Bernardino County to Los Angeles County.

William Sullivan, from San Francisco County to Merced County.

Sheldon K. Wirt, from Los Angeles County to Santa Cruz County.

Resigned (7)

Harold Carter, from Santa Clara County.
William G. Durnin, from Los Angeles County.
Julius H. Hamilton, from Los Angeles County.
Carl E. Horn, from San Francisco County.
Elmer H. Johnson, from Los Angeles County.
Paul B. Kinney, from Los Angeles County.
Harry G. Marxmiller, from Los Angeles County.

In Memoriam

Lavery, William Andrew. Died at Belmont, April 15, 1938, age 65. Graduate of California Eclectic Medical College, Los Angeles, 1899, and licensed in California the same year. Doctor Lavery was a member of the Placer County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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McArthur, Peter R. Died at Los Angeles April 5, 1938, age 69. Graduate of the University of Toronto Faculty of Medicine, 1899. Licensed in California in 1900. Doctor McArthur was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

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Sloan, Orville Joseph. Died at Glendale, April 30, 1938, age 54. Graduate of the University of Nashville Medical Department, 1907. Licensed in California in 1925. Doctor Sloan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Spiegel, Maurice Joseph. Died at Los Angeles, April 22, 1938, age 39. Graduate of the University of Illinois College of Medicine, Chicago, 1932. Licensed in California in 1935. Doctor Spiegel was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CLIFFORD A. WRIGHT.....President
MRS. FRED ZUMWALT.....Chairman on Publicity

News Letter

Dear Auxiliary Members:

As I write this I recall with what trepidation I undertook this task last June, I look back upon the year and realize that some of you made the work, play. I want you to know that I am deeply appreciative of the splendid coöperation you gave to me. To those of you who have hesitated about sending in your reports, your chairman wants *every county represented every month*; the pages allotted us in the state Journal are for that purpose. Help her to help you. Give her of your best and then watch results. Five of our county auxiliaries are new; several are already responding in a manner that speaks well for the future.

From the recommendations below you will see that this department is to have an assistant who will be in charge of these pages. Upon my return the appointment will be made and county publicity chairmen notified.

The Convention report will be published shortly in California and Western Medicine. Some of the more intimate phases of the Convention are published just below.

Cordially yours,

Mrs. Fred H. Zumwalt.

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Report

Because of the arduous duties as editor and publicity chairman, it is our contention that it is asking too much of one person to assume the responsibility of two positions.

We submit the recommendation below to the Board for consideration.

The duties of the editor and publicity chairman are as follows:

1. Preparation of all copy monthly for California and Western Medicine (typing and correcting).
2. Monthly reports to national chairman of publicity.
3. State publicity for newspapers.
4. The making and care of "Auxiliary Log Book."
5. Making of all exhibits to be used at State and National conventions.
6. Editing of semiannual publication, *Courier*.

Due to the growth of the *Courier* it has been the duty of this chairman not only to edit and publish this magazine, but she has had to assume the responsibility of financing it.

Therefore, we recommend that the editor and publicity chairman be given an assistant, whose sole duty shall be the complete charge of the monthly department in California and Western Medicine.

Doane Membership Trophy

We recommend that a definite date be set beyond which the enrollment of members will not be considered in the awarding of the Doane Membership Trophy for the current year and that this date be in advance of the annual convention. (It is suggested that the reports of the county treasurers to the state treasurer, as of March 15, be made a basis of this award.)

We further recommend that a definite policy be established as to whether this award shall be made upon the basis of total enrollment or for new members only, and if the latter, then whether reinstated members shall be counted as new members. (We, the State Board, recommend that the award be made upon the basis of total enrollment.) These recommendations were approved by the House of Delegates.

This Year's Annual Session

A glimpse into a happy past

The Ninth Annual Convention of the Woman's Auxiliary to the California Medical Association has passed (as one figures time), but in memory lives and will linger always. The hospitality of our hostess Auxiliary—that of Los Angeles—can never be forgotten. For our comfort, our pleasure, plans had been made long in advance. Nothing was left undone to make us welcome, and those of us fortunate enough to be their guests heartily say, "Thank you."

Tea on Sunday afternoon—picture a table, beautifully and artistically decorated, presided over by our charming new president, Mrs. Clifford Andrews Wright of Los Angeles, and by Mrs. Eliot Alden, outgoing president of the Los Angeles Auxiliary. (We like to feel that Mrs. Alden belongs to us all, so generous has she been.) At other times during the afternoon Mrs. Robert O'Neal of Santa Monica and Mesdames R. C. Olmstead and Edward W. Jones of Pasadena graciously presided. And we will not forget the pretty young girls who served us. Music was furnished by Pat Dunn and his Manhattans. In the evening the motion picture "Victoria the Great" was shown.

On Monday, May 9, at nine o'clock, the pre-convention Board meeting was held. Then we were whisked away in buses and private cars. Guess where? Have you ever had the privilege of seeing how pictures are made? We did! The studios opened their gates for us and showed us their interesting secrets, and some of us even saw Clarke Gable at luncheon! Then back to the hotel for dinner and the musicale and reception in honor of Mrs. Howard Morrow, wife of the president of the California Medical Association. This was an evening we shall not forget. The Noack Quartet needs no introduction. Sylvian Noack, leader and founder, was concert master of both the Philharmonic and the Hollywood Bowl orchestras for seventeen years. The other members of the quartet are equally well known. The soloist was San Francisco's own *so* beloved, Eva Grunenger Gibson. She is the new president of the San Francisco Auxiliary, and are we proud of her! To those of you who

know her glorious voice mere words are meaningless, and to those of you who have not been so fortunate, you have yet to hear a truly *great* artist.

On Tuesday, May 10, the first general session of the Auxiliary was held at the Hotel Vista del Arroyo. Mrs. Hobart Rogers of Oakland presided in a dignified, gracious manner. A luncheon followed in honor of Mrs. Rogers, presided over by Mrs. Frank Edwin Coulter. Members of the State Advisory Board were guests of honor. Dr. Lowell S. Goin of Los Angeles spoke on *Crux Medicorum*. Mrs. William Henry Sargent of Oakland presented the Doane Trophy to Lassen-Plumas-Modoc County; they have an 80 per cent increase in membership.

In the afternoon a private lecture and demonstration was given at the Planetarium at Griffith Park Observatory by Dr. Dinsmore Alter, after which we were taken to Columbia Square (the new Radio City of the West) to listen in on a national hookup. Those wishing remained and were shown the latest scientific radio apparatus.

In the evening the *President's Ball*. Ask anyone who was there to give you the details—a general good time and dancing to the dawn.

At the meeting of the Auxiliary on Wednesday, the Nominating Committee brought in their report. The following were elected to serve for the coming year: Mrs. Clifford A. Wright of Los Angeles, president; Mrs. Frederick N. Scatena of Sacramento, president-elect; Mrs. A. E. Anderson of Fresno, first vice-president; Mrs. George Calvin of Oakland, second vice-president; Mrs. E. Eric Larson of Los Angeles, corresponding secretary; Mrs. G .Wendell Olson of Fullerton, recording secretary; Mrs. Harry O. Hund of San Rafael, treasurer; Mrs. T. A. Card of Riverside, Mrs. R. Stanley Kneeshaw of San Jose, Mrs. Arthur T. Newcomb of Pasadena, and Mrs. Fred H. Zumwalt of San Francisco, councilors-at-large.

Mrs. Clifford Andrews Wright of Los Angeles, our incoming president, was honored at the luncheon which followed. Mrs. Hobart Rogers presided. The guest speaker was Dr. E. Eric Larson of Los Angeles, his subject being *The Status of Medicine Today*. The honored guests were Dr. John P. Barrow, Dr. Clifford Andrews Wright and the past presidents of the Auxiliary.

The Convention closed with one of the most beautiful and touching ceremonies I have ever witnessed—an old Polynesian Lei ceremony was adapted to our purposes. The lei was likened to the work of our Auxiliary, which had a beginning but no end, whose work is unbounded and whose unity is unquestioned. Mrs. Arthur T. Newcomb, our able Convention chairman, moved us to tears—in fact, there was not a dry eye in that room when three lovely girls, bearing lighted candles, stood silently before the speaker's table while others placed leis of white carnations around the throats of the past presidents, who were standing, symbolizing love sent to the absent ones.

In the afternoon the Huntington Library, with its exhibits and gardens, was visited and later we were taken to Forest Lawn to view the noted art window, "The Lord's Supper."

Will you answer me just these two questions?

How Mrs. Arthur Newcomb managed to maintain such composure after the arduous duties that had been hers during these past months?

Why Mrs. Hobart Rogers looked *so relieved* when she turned over the duties of president?

Mrs. Fred H. Zumwalt.

Component County Auxiliaries

Alameda County

The April meeting of the Woman's Auxiliary to the Alameda County Medical Association was held in honor of our state president, Mrs. Hobart Rogers. At this meeting we had several State Board members as our guests: Mesdames Harry O. Hund, Fred H. Zumwalt, Robert M. Furlong, William H. Sargent, and Harold Trimble.

After a delightful luncheon, Dr. Helen McKnight Doyle gave us a very interesting review of her book, "A Child Went Forth." Our program continued with a lovely group of violin selections given by one of our talented members, Mrs. Chelsea Eaton, accompanied by her sister, Miss Margaret Rubino. The afternoon closed with an informal get-together of the attending 125 members.

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Butte County

The Butte County Auxiliary was hostess to the wives and guests of the members of the Northern California Medical Association when that group met in Chico on April 16. About twenty guests from the surrounding country were present.

Mrs. J. H. White, President of the Butte County Auxiliary, welcomed members and their friends at a tea given at her home in Mansion Park. A drive through Bidwell Park and through fields brilliant with wild flowers followed. Later Mrs. N. T. Enloe opened her lovely home for a delightful buffet supper. Mrs. P. L. Hamilton, a Chico Auxiliary member, entertained with a group of songs. Mrs. Enloe was assisted in receiving by Mrs. C. C. Landis, Mrs. E. L. Meyers, and Mrs. J. P. Fabian. It was a very enjoyable day.

The Chico women decorated the tables for the doctors' dinner, held that night at the Hotel Oaks. The speakers' table was very beautiful, with its profusion of flowers artistically arranged.

Several of our members may attend the State Convention and later the National Convention. We hope to gain knowledge that will prove of benefit to the local unit.

Mrs. J. H. White, *President.*

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Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association held its regular luncheon meeting at twelve o'clock at the Annandale Country Club in Pasadena, with 145 members present. The program was in charge of the newly formed Pasadena branch.

This is always one of the most delightful meetings of the year, and attracts a large attendance. The tables were a profusion of flowers, beautifully arranged, and the buffet luncheon very attractive and lavish.

Mrs. Edward Winslow Jones of Altadena acted as hostess and opened the meeting, then turned the gavel over to the president, Mrs. Eliot Alden.

The guest speaker was Dr. Lester Brooks Rogers, Executive Director, Associated Hospital Service of Southern California, who spoke on group hospitalization. Several guest artists gave a splendid musical program.

Mrs. Robert L. Carroll, *Corresponding Secretary.*

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Marin County

Miss Rose Resnick, blind concert pianist, and her Seeing Eye dog were the special guests of the Marin County Woman's Auxiliary at its dinner meeting on Thursday, April 28, at the Marin Golf and Country Club.

Miss Resnick played several brilliant request numbers. She then spoke to the Auxiliary, giving a very enlightening discussion concerning the training school in New Jersey for Seeing Eye dogs. She explained also that there is a great need for Braille music, especially among those blind who make music their means of support. Short selections for radio presentation are particularly scarce.

At the business meeting, the Nominating Committee gave its selection of officers for the following year, which will be voted on at the next meeting.

Maylon Conroy, *Secretary.*

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Orange County

The May meeting of the Woman's Auxiliary to the Orange County Medical Society was held at Long Beach's Pacific Coast Club, following a delightful luncheon and program.

Officers who were nominated at the April meeting were elected to office. They were: Mrs. Hiram Currey of Santa Ana, president; Mrs. E. H. Kersten of Anaheim, vice-president; Mrs. J. B. Price of Santa Ana, secretary; and Mrs. E. J. Steen of Anaheim, treasurer.

Mrs. E. T. McFadden of Santa Ana, who reviewed the *Life of Madame Curie* as the program feature of the afternoon, was introduced by Mrs. Dexter Ball. Hostesses for the day were the Mesdames D. C. Cowles of Fullerton, H. E. Robbins of Garden Grove, Arthur Nies of Orange, Mrs. Lawrence Whittaker of Huntington Beach, and Mrs. L. Wilson of Anaheim.

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Riverside County

The April meeting of the Woman's Auxiliary to the Riverside County Medical Society was held at the home of Dr. and Mrs. Ralph Smith, with a very good attendance. Reports show dues very well paid and enough money in the treasury to meet local obligations, such as our yearly contribution to the Community Settlement House, *Hygeia* in the schools, etc.

Plans were made for a tea to be held at the home of Dr. and Mrs. Ray B. McCarty as a last meeting for the season.

Mr. Donald H. Biery of Sherman Institute gave an educational and entertaining talk on the Indians and their health problems, indicating that the Government has really done marvels for the health of the redman.

Later, husbands came in for refreshments and we were entertained by a musical program given by Dr. Ben Garrison and Mrs. E. G. Miller.

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San Diego County

The May luncheon meeting of the Woman's Auxiliary to the San Diego County Medical Society was held at the Men's University Club on May 17, the meeting having been changed because of the State Convention in Pasadena.

Mrs. Eaton MacKay gave a most interesting talk upon the *History of Hospitals.* This appropriately followed Hospital Day on May 12 preceding.

Mrs. Hiram J. Newton gave the monthly March of Medicine talk from *Hygeia.*

Brief annual committee and convention reports were given.

Representatives for the American Medical Association Convention in June were anounced as follows: Mrs. C. O. Tanner, Mrs. W. H. Newman, and Mrs. Elliott G. Colby.

The annual election of officers took place: Mrs. C. O. Tanner, president; Mrs. R. Emerson Bond, first vice-president; Mrs. T. M. Cuningham, second vice-president; Mrs. Hiram Newton, secretary; Mrs. Alex Lesem, treasurer; Mrs. Edwin H. Kelly and Mrs. Alfred J. Cooper, members-at-large.

The San Diego Auxiliary is planning to do definite legislative work in the fall. They have also been coöperating closely with the Women's Field Army for the Control of Cancer, headed by Mrs. R. A. Schneiders, City Captain.

At the State Convention, San Diego County had an exhibit of the pages in the County Medical Bulletin, arranged by Mrs. A. J. Hoefer. It is hoped that this may be exhibited in the American Medical Association Convention in June.

The June meeting will be in the form of a tea honoring the new Board. This affair is a most delightful tradition of the San Diego Auxiliary. Mrs. R. Emerson Bond.

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San Francisco County

The 1937-1938 fiscal year closed with the annual session on April 19, with the president, Mrs. Hans Barkan, retiring. Six general meetings were held at the home of the San Francisco County Medical Society, 2180 Washington Street, on the third Tuesdays of September, October, November, January, March, and April. The meetings were devoted to hearing major health problems discussed by the following speakers:

Present Status of Bovine Tuberculosis and Its Relationship to Public Health, Philip H. Pierson, M. D.

Campaign for the Control of Venereal Diseases, Russell V. A. Lee, M. D.

Recent Advances in Our Knowledge of the Treatment of Infantile Paralysis, Harold K. Faber, M. D.

Effect of Motion Pictures on Children, Mary H. Layman, M. D.

The Medical Profession's Present-Day Problems, William C. Voorsanger, M. D.

Organization and Functions of the Public Health Department, J. C. Geiger, M. D.

The study group, under the leadership of Mrs. Julius Sherman, met on the first and third Monday afternoons throughout the current year. The history of medicine, public health, and other allied matters furnished the topics for these meetings. Mrs. Frank H. Rodin was chairman of arrangements. Mrs. Rodin also served as county *Hygeia* chairman.

Mrs. Hobart Rogers, State President of the Woman's Auxiliary to the California Medical Association, made an official visit to the Auxiliary at the regular meeting on November 16, at which time she gave a most inspiring talk. The purposes of our organization were clearly outlined, and the importance of the membership supporting the county, state, and national auxiliaries emphasized.

A formal tea for members and guests was given by the officers and directors on November 29 at the society's headquarters, in honor of Mrs. Hobart Rogers. The program consisted of travelogue pictures of Mexico.

Honoring their national president, Mrs. Augustus S. Kech of Altoona, Pennsylvania, members and guests assembled at a formal luncheon on Tuesday, February 8, at the Western Women's Club. Several state officers and county presidents attended. Mrs. Kech delivered a brilliant address, and called attention to the national convention of the Woman's Auxiliary to the American Medical Association, set for June 13 to 17, in San Francisco. Mrs. J. C. Geiger is chairman of arrangements, with Mrs. William H. Sargent serving as vice-chairman.

The evening function of the year was a formal Valentine dinner on February 14 at the beautiful home of the Society, which had been transformed into a perfect setting for the occasion. A musical program and dancing constituted the entertainment of the evening.

Honoring the new members, an informal reception was held on the afternoon of March 15, following the business session of the general meeting. Tea was served in the library. The new members for the year number seventy, making a total of 190 members.

The Nominating Committee, consisting of Mrs. Howard B. Dixon (chairman), Mrs. Ernest C. Dickson, Mrs. Philip H. Pierson, Mrs. John J. Sampson, and Mrs. A. G. Folte, submitted their report on March 15. There being no nominations from the floor, the report was accepted in full.

New officers and directors, installed on April 19 are the following: Mrs. Thomas E. Gibson, president; Mrs. Edmund J. Morrissey, first vice-president; Mrs. A. Lincoln Brown, second vice-president; Mrs. Fred D. Fellows, recording secretary; Mrs. Wilber F. Swett, corresponding secretary; Mrs. William C. Voorsanger, Mrs. E. S. Kilgore, and Mrs. Rea E. Ashley, directors. Mrs. William H. Sargent of Oakland, a past state president, presided as installing officer.

Following the business session of April 19, Miss Helen Zumwalt rendered a beautiful selection of songs. An informal tea, given by the officers and directors for the retiring and incoming presidents, completed the afternoon's program. Mrs. Harry R. Oliver, *Publicity Chairman.*

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San Mateo County

The organization meeting was called for April 7. Mrs. Hobart Rogers acted as chairman, and told us of the reasons for and the aims of the organization. At the meeting held on April 20, the following officers were elected: Mrs. Carl Benninghoven, president; Mrs. George W. Sevenman, vice-president; Mrs. James Warburton, recording secretary; Mrs. J. G. Bridgman, Corresponding Secretary; Mrs. Ralph D. Howe, treasurer.

At this meeting twenty-three of the doctors' wives—all of whom were present—joined the Auxiliary.

A meeting of the Board of Directors has been called for May 4, at which time plans for the future will be discussed.

Mrs. J. G. Bridgman, *Corresponding Secretary.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Academy of Pediatrics, Del Monte, June 9–11. Clifford G. Grulee, M. D., 636 Church Street, Evanston, Illinois, Secretary.

American Academy of Tuberculosis Physicians, San Francisco, June 17–18. Arnold Minnig, M. D., 638 Metropolitan Building, Denver, Secretary.

American Association of Medical Milk Commissions, San Francisco, June 13–14. Paul B. Cassidy, M. D., 2037 Pine Street, Philadelphia, Secretary.

American Dermatological Association, Del Monte, June 9–11. Fred D. Weidman, M. D., 36 Hamilton Walk, Philadelphia, Secretary.

American Heart Association, San Francisco, June 10–11. Howard B. Sprague, M. D., 50 West Fiftieth Street, New York, Secretary.

American Medical Women's Association, San Francisco, June 12–14. Helen A. Cary, M. D., 1634 N. E. Halsey Street, Portland, Oregon, Secretary.

American Ophthalmological Society, San Francisco, June 9–11. Eugene M. Blake, M. D., 303 Whitney Avenue, New Haven, Connecticut, Secretary.

American Proctologic Society, San Francisco, June 11–13. Curtice Rosser, M. D., 710 Medical Arts Building, Dallas, Texas, Secretary.

American Psychiatric Association, San Francisco, June 6–10. W. C. Sandy, M. D., State Education Building, Harrisburg, Pennsylvania, Secretary.

American Radium Society, San Francisco, June 13–14. F. W. O'Brien, M. D., 465 Beaon Street, Boston, Secretary.

American Rheumatism Association, San Francisco, June 13. Loring T. Swain, M. D., 372 Marlborough Street, Boston, Secretary.

American Society of Clinical Pathologists, San Francisco, June 9–11. A. S. Giordano, M. D., 531 North Main Street, South Bend, Indiana, Secretary.

Association for the Study of Allergy, San Francisco, June 9–10. J. Harvey Black, M. D., 1405 Medical Arts Building, Dallas, Texas, Secretary.

Association for the Study of Internal Secretions, San Francisco, June 13–14. E. Kost Shelton, M. D., 921 Westwood Boulevard, Los Angeles, Secretary.

National Tuberculosis Association, Los Angeles, June 20–23. Charles J. Hatfield, M. D., Seventh and Lombard Streets, Philadelphia, Secretary.

Western Branch of American Public Health Association, Portland, Oregon, June 6–8. William P. Shepard, M. D., 600 Stockton Street, San Francisco, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of June is as follows:

Thursday, June 2—KECA, 11:00 a. m., The Road to Health.
Saturday, June 4—KFI, 9:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, June 9—KECA, 11:00 a. m., The Road to Health.
Saturday, June 11—KFI, 9:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, June 16—KECA, 11:00 a. m., The Road to Health.
Saturday, June 18—KFI, 9:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, June 23—KECA, 11:00 a. m., The Road to Health.
Saturday, June 25—KFI, 9:00 a. m., The Road to Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, June 30—KECA, 11:00 a. m., The Road to Health.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Los Angeles County Grand Jury Votes Audit.—County grand jurors recently voted authorization for three special audits. They are as follows:

1. An audit of the expenses of the General Hospital, designed to determine the cost to the taxpayer in the care of indigent sick. . . .

First Syphilis and Tuberculosis Control Health Contests.—This year, as a part of the City Health Conservation Contest conducted annually by the Chamber of Commerce of the United States in coöperation with the American Public Health Association, awards are being made for the most effective community-wide programs for syphilis control and tuberculosis control. . . .

A few of the items considered by the committee were:

The comprehensiveness of case-finding and follow-up services in connection with tuberculosis and syphilis;

The facilities provided for diagnostic and treatment purposes;

And the extent of group participation in programs of education and control.

These and many other items were carefully considered by the committee of health experts in judging the effectiveness of a city's efforts to combat tuberculosis and syphilis.

Fourth Annual Rural Health Conservation Contest Announces Winners.—The Rural Health Conservation Contest, conducted annually by the Chamber of Commerce of the United States in coöperation with the American Public Health Association and financed by the W. K. Kellogg Foundation of Battle Creek, Michigan, announces, among others, the following winner for the 1937 contest:

In the Western Division, the winner is Clallam County, Wash., and awards of merit go to Spokane County, Wash., Yakima County, Wash., and Bannock County, Idaho.

This year, for the first time, the rural health units of Canada were included in a contest sponsored by the Canadian Public Health Association in coöperation with the American Public Health Association. The response in the Canadian contest has been most gratifying. There are at present only forty-one full-time health units eligible for competition. Of these, thirty-five entered and thirty-two of them submitted schedules for grading. In the contest in the United States there were 241 entries.

Some of the points considered by the committee of health experts entrusted with making the awards are:

1. The extent to which the water supply is protected.
2. The point at which sanitation has advanced in rural homes.
3. The safety of the milk supply.
4. Adequate care of prenatal cases.
5. Medical supervision of infants.
6. The availability of well-trained nursing service.
7. The degree in which local physicians and dentists aid in the public health program.
8. Activities to control tuberculosis and syphilis.

These and many other points are used in grading a county or district competing in the contest.

University of Southern California Medical Alumni Association. — The University of Southern California Medical Alumni Association announces a dinner meeting during the American Medical Association session at San Francisco, to be held at the Hotel St. Francis, Room 210, on Wednesday evening, June 15.

All University of Southern California Alumni who are planning to attend the American Medical Association Convention are urged to attend and renew old friendships. An excellent menu and evening of entertainment have been planned. For further information, address Anton Laubersheimer, M. D., Secretary, 1930 Wilshire Boulevard, Los Angeles.

American Medical Golfing Association.— You are cordially invited to play in the Twenty-fourth Tournament of the American Medical Golfing Association on Monday, June 13.

Place—The very smart San Francisco Golf and Country Club, San Francisco. The Club is reserved for the American Medical Golfing Association exclusively on June 13.

Hours for teeing off—7:30 a. m. to 2:30 p. m.

Dinner—At the Club, 7 p. m. Positively no speeches! By-laws state no trophy or prize may be awarded a Fellow who is absent from the annual banquet. Those who remain will be well repaid.

Prizes—Fifty beautiful trophies and prizes—for experts, dubs, beginners—in nine events, both gross and net. Only active Fellows of the American Medical Golfing Association may compete for prizes.

Cost—Seven dollars covers green fee, dinner, tournament fee, refreshments, exceptional entertainment, and prizes. (New Fellows pay an additional enrollment fee of $3.)

Handicaps—At the first tee, present your official handicap, certified by your home club secretary; otherwise the Committee on Handicaps has the right to set your handicap. No handicap over 30, except in the Kickers (Blind Bogey), which is unlimited.

Starting—Foursomes with starting time will be arranged on request. Write Dr. James W. Morgan, Chairman, 384 Post Street, San Francisco.

An Extraordinary Party is being arranged by the San Francisco Committee. Come to see your old friends, make new ones, and, incidentally, try for a nice prize.

Additional information follows:

Local Committee, Dr. James W. Morgan, Chairman, 384 Post Street; Drs. George A. Gray, Ernest D. Chipman, William G. Moore, and George McClure.

FIXED COMPETITION

Morning and Afternoon

1. Association Championship, 36 holes gross. The "Will Walter" Trophy (perpetual), donated and named by the American Medical Golf Association in 1922.
2. Association Handicap, 36 holes net. The "Detroit" Trophy. Donated by the Detroit hosts of 1916.
3. Championship Flight, first gross, 36 holes (formerly Choice Score Championship). The "St. Louis" Trophy (perpetual). Donated by the St. Louis hosts of 1922.
4. Championship Flight, first net, 36 holes. The President's Trophy. Donated by Dr. Walt P. Conaway, Atlantic City, New Jersey.

Afternoon or Morning

5. Low Gross, 18 Hole Gross Championship (first 18 holes played). The "Golden State" Trophy (perpetual). Donated by the San Francisco hosts of 1923.
6. Low Net, 18 Hole Handicap Championship. The "Ben Thomas" Trophy (perpetual). Donated by Philadelphia hosts of 1931.
7. Maturity Event. Limited to Fellows over sixty years of age. The "Minneapolis" Trophy. Donated by the Minneapolis hosts of 1928.
8. The "Oldguard" Championship. The "Wendell Phillips" Trophy (perpetual). Eighteen-hole handicap, limited to competition of past presidents. Donated and named by the American Medical Golf Association in 1930.
9. Kickers' Handicap. The "Atlantic City" Trophy (perpetual). Donated by the Atlantic City hosts of 1937.
10. Other events and prizes to be announced at the first tee.

Medical Alumni of Northwestern University. — In connection with the American Medical Association meeting in San Francisco, the Medical Alumni of Northwestern University Medical School will hold a luncheon on June 15 at twelve o'clock at the Whitcomb Hotel, 1231 Market Street. Dr. James G. Carr will be the speaker. Please make your reservation early by calling the Whitcomb Hotel. For further information, address F. J. Carlson, M. D., 371 Thirtieth Street, Oakland, California.

Development of Public Health Organization.—The progress achieved in the organization of public health departments in California during the past twenty years is shown in the following data:

In 1918 there was but one full-time county health department in California. This comprised only the rural territory of Los Angeles County. There were three cities in 1918 that maintained full-time public health service. They were Los Angeles City, San Francisco, and Palo Alto. These four units comprised 35.9 per cent of the total population of the state.

In 1928 there were ten counties maintaining full-time public health service and, in addition, four cities which provided similar service. Altogether, they constituted 64.5 per cent of the state's total population.

In 1938, there are twenty counties and four additional cities which maintain full-time public health service. These constitute 81 per cent of the total population of the state.

San Jose Controls Dogs.—No less than 2,900 stray dogs were captured in San Jose last year, according to the annual report of the city health department, H. C. Brown, M. D., Health Officer. During the year ninety-four persons were bitten by dogs, 103 dogs were placed under spot quarantine, twenty-three heads suspicious of rabies were sent to the laboratory (sixteen of which proved positive for rabies), three persons were bitten by rabid dogs and two persons by rabid cats, and two persons had wounds contaminated through contact with rabid animals. The Pasteur treatment was administered to seven individuals. This constitutes a most commendable record in the control of a most dangerous and devastating disease. It is largely through activities of this sort that rabies is held in check. Doctor Brown deserves high praise for conducting a successful program in the control of rabies within his community.

American Public Health Association Annual Session. "Public Health in the World of Tomorrow" is the central theme of the sixty-seventh annual meeting of the American Public Health Association to be held in Kansas City, Missouri, October 25–28.

Recognizing that the responsibilities of the health official have expanded by sheer force of necessity into fields of diagnosis and treatment, considered in the very recent past as beyond the circle of health department obligations, the program of the Association's sixty-seventh convention will attempt to look around the corner and see what is ahead for the career man or woman in the public health profession.

It is agreed in Association councils that the advance in public health has been so rapid in the last half-dozen years that a clarification of current objectives and policies is urgently needed. The convention will sound that note at the beginning of its deliberations, getting under way with a session devoted to a discussion of the present state of the health of the nation. Thereafter, the central theme, "Public Health in the World of Tomorrow," will be emphasized throughout the several days of meetings.

The American Public Health Association is a society of professional public health workers. Its membership numbers nearly six thousand and includes health officers, laboratory workers, vital statisticians, industrial hygienists, child hygienists, public health engineers, food and drug experts, health education authorities, nurses, epidemiologists, and others, who specialize in disease prevention and health promotion.

An attendance of three thousand is expected at the Kansas City annual meeting, drawn from every state in the Union, from Canada, Cuba, Mexico, and from abroad.

Another Human Death from Rabies.—A dairyman of Kings County, about the middle of March, noticed that one of his cows did not give milk. On the following day, he observed that the cow was obviously ill and that there was considerable ropy saliva; also that the animal was experiencing difficulty in swallowing. In attempting to treat the cow, he placed his hand deep in the animal's mouth. In so doing, the skin on his knuckles was abraded considerably through contact with the cow's teeth. The animal did not bite, but his hand was scratched on the animal's teeth. No attention was paid to the injury, and the cow died that night. A veterinarian sent the head of the animal to the state laboratory because the animal had died of symptoms typical of dumb rabies.

On the following day, word was received of positive findings in the laboratory. On that afternoon, the dairyman visited his physician and the Pasteur treatment for the prevention of rabies was instituted. At least twelve doses of vaccine were administered, the last two having been given in the patient's home because he was too ill to go to the doctor's office. On March 29 he came for treatment, complaining of headache and discomfort. He remained in bed the following day, March 30, and on the 31st was unable to leave his bed. His temperature rose, and on April 1 he had diminished reflexes, a slight stiff neck, high temperature, and was somewhat lethargic. Death came on April 3. At no time was the patient highly excitable and at no time did he have convulsive seizures. There was no particular difficulty in swallowing.

A postmortem examination was made and the brain was sent intact to the Stanford Medical School at San Francisco, where Negri bodies were found, confirming diagnosis of rabies.

It would appear that about March 1 a pack of dogs killed and partially ate one of the calves on the ranch. During the past few months, two coyotes within the area were found to be rabid, and a number of rabid dogs have been discovered within a few miles of the ranch. While the case is rather atypical of rabies, there can be no question relative to the diagnosis.

Sacramento Wins Health Award.—The city of Sacramento, Dr. Herbert F. True, City Health Officer, has been awarded first place among cities from 50,000 to 150,000 population in the 1937 Inter-Chamber of Commerce City Health Conservation Contest. This award is based upon safety of the water supply, satisfactory sewage disposal, adequate supervision over milk supplies, medical and nursing service for mothers and infants, safeguarding of the community by recognized preventive measures with special emphasis on school health, control of tuberculosis and venereal diseases, together with many other activities that have to do with the conservation of the public health.

A few weeks ago Sacramento was also awarded first place among cities having similar populations for making the best safety record among such cities in the United States.

The Inter-Chamber of Commerce Contest is sponsored by the United States Chamber of Commerce and the American Public Health Association. Sacramento was first entered in the contest in 1931, when its health department ranked twentieth; in 1932 it stood fifteenth; in 1933, twelfth; in 1934, ninth; in 1935, sixth; in 1936, fourth; and in 1938, first.

Some of the 1937 achievements of this department are the establishment of a venereal disease clinic which is a model of efficiency, improvement in laboratory equipment, tuberculin testing in the schools with the assistance of the Sacramento Tuberculosis Association, a campaign for better care of children's teeth sponsored by the Sacramento Dental Society, and the provision of increased and better services for maternal care.

The Sacramento Chamber of Commerce committee that has been instrumental in the development of Sacramento's place in the contest is composed of Dr. Herbert F. True, Dr. Nathan G. Hale, and Dr. Frederick N. Scatena. The City Council, as well as the city manager of Sacramento, James S. Dean, deserve credit for the excellent record made by the Sacramento City Health Department. Mr. Dean has at all times provided the essential support that makes possible the activities of a modern full-time public health administration.

Alpha Epsilon Iota at American Medical Association Session.—Alpha Epsilon Iota Fraternity will meet on Wednesday, June 15, 12:15 p. m., on the roof dining room of the Whitcomb Hotel.

Alpha Epsilon Iota is the national medical women's fraternity, with local chapters at both Stanford and University of California Medical Schools.

For further information, address Mary H. Layman, M.D., 2156 Pacific Avenue, San Francisco.

Ninth Annual City Health Contest Announces Winners.—The Chamber of Commerce of the United States, in coöperation with the American Public Health Association, recently announced the following awards for the 1937 City Health Conservation Contest:

In Group IV (cities of 50,000 to 100,000 population) Sacramento gets the first award, and other awards go to Evanston, Ill., Newton, Mass., Greensboro, N. C., and Saginaw, Mich.

The 1937 contest had 263 entries.

The City Health Contest is conducted anually by the Chamber of Commerce of the United States in coöperation with the American Public Health Association. Awards are given, in each of the six population groups, to those competing cities which, in the opinion of a committee of health experts, have during the past year dealt most effectively with their local health problems.

The committee made it clear that these are *not* prizes for the healthiest cities; they are prizes for the most effective efforts to meet local health problems. Awards are not based on health department programs alone, but rather on the community-wide efforts of all agencies and groups including the work of private practitioners of medicine and dentistry.

Some of the activities considered in judging the contest are: Safety of water supply, satisfactory sewage disposal, adequate supervision of milk supply, planned medical and nursing service for mothers and infants, safeguarding the community by recognized preventive measures, with special emphasis on school health and control of tuberculosis and venereal disease.

These and many other activities are considered in judging a city's health program.

Medical School Plans Camp for Diabetic Children.—The University of California is to attempt something new in the way of recreation—a summer camp for diabetic children—provided negotiations now under way are successfully concluded. Keenly aware of the fact that a number of these children, particularly among the poorer classes, are being denied the delights of vacationland, with its hiking, swimming and kindred sports, merely because of a digestive derangement, the Department of Pediatrics of the University's medical school is attempting to remedy the situation. Provided the proper financial support can be arranged, the first camp will be opened this year, to run for the last two weeks in July and the first two weeks in August. The site of the camp will be announced later.

According to Dr. Francis S. Smyth, Professor of Pediatrics, and Dr. Mary B. Olney, Instructor in Pediatrics, there is no reason why diabetic children should be denied this recreation. With the exception of their single complaint, the children selected would be as fit in every way to enjoy the recreational pursuits that other children enjoy. Boy Scout, Girl Scout, and other recreational and character-building agencies have been interested in these children, but have not been able to supply the careful periodic treatment and special diets that would be necessary, in addition to their camp routine. The physicians state that the problem can be easily solved through the presence in the camp of a trained pediatrician and a small staff of assistants.

It is proposed that Doctor Olney take charge of the camp, together with a voluntary interne, two nurses, and a dietitian. As the diabetic, who is not suffering from any communicable disease, can mix freely with other children, the camp would possibly give them the added pleasure of such associations, under the most wholesome and healthful influences. According to Doctor Olney, such camps have been operated with great success in the states of New York and Ohio, proving not only a great relief to the child but to the parents as well.

Medical Book-Plate Contest in Los Angeles.—The "Library Associates" of the Medical Library of the Los Angeles County Medical Library have offered a $25 prize for a book-plate design for "Library Memorial Fund" books. The Library Associates recently brought that fund into existence. Conditions of the contest follow:

1. Designs may be submitted by any member of the Los Angeles County Medical Association or other individual.
2. Designs must be original.
3. A single individual may submit any number of designs.
4. Designs must be complete and ready for reproduction.
5. All designs submitted shall become the sole property of the Library Associates, but may not be utilized without the payment of $25 to the designer.
6. The contest will close on July 1. Further information may be obtained from the secretary of the Library Associates, Hyman Miller, M. D., 672 South Westlake Avenue, Los Angeles.

Stockton Student Wins Gorgas Essay Contest.—Dr. George Crile, President of the Gorgas Memorial Institute, has advised the Director of the California State Department of Public Health that Marguerite Lujan of Stockton High School, Stockton, has won the California state prize in the Ninth Gorgas Essay Contest. Her essay, together with those from forty-seven other states and the District of Columbia, will be judged by a national committee in the national essay contest conducted by the Institute.

The Gorgas Essay Contest has been conducted annually under the direction of the late Admiral Carey T. Grayson, who was for many years chairman of the Executive Committee of the Institute. Following his recent death, Dr. George Crile, President, has directed the contest.

More than 18,000 high school juniors and seniors competed in the present competition, in which were included public, private, and parochial schools from every state in the Union. The subject assigned was "The Achievements of William Crawford Gorgas and Their Relation to Our Health." The winner of the national contest will receive $500 in cash, with a travel allowance of $200 for a trip to Washington to receive the prize, which is customarily presented by the President of the United States at the White House.

Growth Hormone Isolated Further at University.—An important step toward the final, complete purification of the growth hormone, a substance controlling growth which is secreted by the anterior pituitary gland, has been announced by Dr. Herbert M. Evans, Professor of Biology, and three colleagues, Drs. Miriam E. Simpson, Quentin Bartz, and N. Uyei, at the University of California.

In a scientific paper published recently, the scientists declared, "An approximate 70 per cent increase in yield of the growth hormone and five-fold increase in potency has been obtained." This is the greatest concentration and purification of this substance that has ever been achieved.

The hormone is one of several produced by the anterior pituitary gland, situated at the base of the brain and commonly known as the master gland in man and animals. The growth hormone controls the general development of the entire body. Where there is an overproduction of this hormone by the pituitary gland, giants are produced. On the other hand, if there is a deficiency of the hormone, dwarf-like men and animals are produced.

Up to the present time the isolated hormone has been used in treating only a very few cases of arrested human development due to the fact that impurities still exist in the best concentrations it has been possible to obtain. Doctor Evans' announcement of the great increase in concentration and potency of the hormone achieved at the University indicates that the day may not be far distant when it will be produced in its pure state. Once this purification process is successfully completed, Doctor Evans believes, it will be possible to produce spectacular improvement in children who are stunted because of a pituitary deficiency.

The hormone was first isolated at the University of California by Doctor Evans and a colleague, Dr. J. A. Long, associate professor of embryology. Since that time every effort has been made to obtain greater concentrations of the substance, and experiments will continue until it is finally purified.

Visual Defects in College Students.—Approximately three hundred thousand students in American colleges and universities—or nearly 25 per cent of the entire enrollment—are handicapped in their studies by serious visual defects, it was disclosed in a recent report of the Eye Health Committee of the American Student Health Association.

Surveys of students' vision reveal that the principal defects are astigmatism, farsightedness, and a lack of eye coördination, according to the report, prepared for the committee by Anette M. Phelan, Ph.D., Associate in Health Education, National Society for the Prevention of Blindness. R. W. Bradshaw, M. D., Director of Student Health at Oberlin College, is chairman of the committee.

Pointing out that the discovery and correction of visual defects is of vital concern to college administrators, the report urges a full ophthalmic examination for all students. It calls attention also to the fact that not only do students enter college with twice as many visual defects as their contemporaries who go into industry, but that one in six entering with presumably good vision will need glasses or treatment before graduation, and one in eleven will suffer a serious loss of visual acuity.

Visiting Doctor Tells Adventures in Monkey Quest. Tales of thrilling adventure are not often made part of the calm, quiet routine of a great medical center, but one such tale was told in the University of California Medical School here recently that will not soon be forgotten. The narrator was Professor John Fulton, Sterling Professor of Physiology at Yale University, recently returned from the Philippine Islands in a quest for the rare Tarsius monkey. The brain structure of this monkey bears a close resemblance to that of man, and science has placed a particularly high value on it on that account.

In order to track down the monkey, Professor Fulton was compelled to go to its retreat in the jungle fastnesses of the Island of Bohol. The island, which claims a population of 50,000 natives and only two whites, presents a challenge to the hardiest explorer, but Professor Fulton was equal to the situation. After varying adventures he was able to capture two of the monkeys, and he also captured five lemurs. As the monkeys subsist chiefly on insects, the professor was hard-pressed to get a sufficient supply to last through the long ship voyage to the United States.

The professor's hard work was to go for naught, however. One of the monkeys and three of the lemurs died before the ship reached Honolulu. The other monkey partook of a big Honolulu spider, and a few hours thereafter expired. Professor Fulton ascribes the death of the monkeys to differences in atmospheric pressures particularly. In spite of his bad fortune, he says he is going back again to search for more monkeys as soon as the big Clipper airplanes can provide an air-conditioned room for him. He is sure then that he will be able to "bring 'em back alive."

While here Professor Fulton lectured to the students and staff of the Medical School on nerve coördination.

Physical Upsets Can Be Caused by Worry Alone.—Any individual who indulges in worry of one sort or another over a long period of time will invariably develop changes in the gastro-intestinal tract. Many of those who feel "all upset" in their digestive processes are usually upset in their minds only, and are speedily cured as soon as their minds are set aright.

This is the statement of Dr. Paul A. Gliebe, assistant clinical professor of neuropsychiatry in the University of California Medical School, made after a study of many patients offering themselves for treatment for ills of the digestive organs. Doctor Gliebe related the case of one man who worried so much and so long over the fact that his wife was ill of stomach ulcers that he developed the same type of ulcers himself. His wife was cured under treatment. He ceased to worry about her, and his own disorder thereupon disappeared in due time with little or no attention.

Doctor Gliebe states that, in the hands of a physician trained to utilize the close relationship between mental and physical ailments, many a patient can "talk himself well." Illnesses that are the result of emotional stress and strain usually show marked improvement as soon as the cause is

removed and the patient can achieve some measure of mental discipline.

"The patient with a neurotic illness suffers as much, if not more, than the individual with a structural disease," Doctor Gliebe states. "To the physician these complaints must be considered real and not imaginary. Patients are frequently made worse by repeated x-ray examinations or by other examinations that are done solely to impress him. These patients cannot be hurried. If given sufficient time and the patient is permitted to talk about things other than his symptoms, there is a remarkable shifting of interests and a corresponding change for the better."

Medical Men Help Puncture Old Tradition.—The hide-bound tradition that life ends at forty—or perhaps fifty—as far as industrial and business fitness, productiveness and efficiency are concerned, has now been publicly challenged by one of the very best authorities on the subject—the medical profession. Not only is that tradition being questioned in the ranks of the medical fraternities, but the movement to keep older persons in productive employment, either on a piecework or full-time basis, is being strongly backed by the profession from one end of the country to the other.

These developments were brought out in sharp relief at the recent annual meeting of the American College of Physicians, according to Dr. William J. Kerr, Professor of Medicine in the University of California Medical School and president of the College. As the convention was held in New York, Doctor Kerr had an excellent opportunity to see how that state was refusing to accept the tradition regarding the supposedly decrepit and unfit forties. As a guest of the city, he was taken to Welfare Island, where, in a great hospital, the community is not only returning many of its old folks to gainful employment, but is helping overcome many of the bugaboos regarding the disabling effects of the diseases of the aged. San Francisco is planning a similar hospital at the Laguna Honda Home, the plans for which are in the hands of Dr. J. C. Geiger, Health Officer.

Press Clippings.—Some news items from the lay press, on matters related to medical practice, follow:

Boy Bitten by Mad Dog Sought

Health Officials Trying to Learn Identity of Unknown Victim

Somewhere in Los Angeles a newsboy may be infected with rabies and not yet know it.

Health authorities want that unidentified newsboy to come to the city health department at the City Hall at once for treatment.

The boy was bitten two days ago by a brown mongrel dog at 211 South Fickett Street. The dog was found on a laboratory test to have rabies.

The appeal for the boy to appear was made yesterday by Dr. George Parrish, City Health Officer, who received a report on the incident from Dr. F. B. Gage, in charge of the rabies division of the department.—Los Angeles *Examiner*, May 20.

* * *

"Licensed Dog, If Rabid, Safe from Catcher"

"County Unprotected," Health Head Tells Frank Davis

Even if they are suffering from rabies licensed dogs running the streets in Altadena, Monrovia, Arcadia, San Marino, and other territory, not including Pasadena, affected by the recent quarantine cannot be impounded or taken into custody by county or city health authorities. Any officer who impounds a licensed dog, regardless of its condition, is subject to contempt-of-court under the temporary injunction which is effective until Wednesday, April 27.

Such was the interpretation of the injunction given by Dr. J. L. Pomeroy, county health officer, to Frank Foster Davis, Altadenan, who has been leader in the movement for a directed quarantine as the best method of rabies control.

Old County Law

The injunction, secured by James Lindsay, secretary of the Tailwagger Foundation of America, places into effect a county ordinance adopted in 1921 which makes it impossible for any officer to pick up a dog wearing the proper license.

"While we are still able to pick up all unlicensed dogs, we are helpless to do anything if the dog wears a license," Doctor Pomeroy told Mr. Davis yesterday. "This holds good whether the dog has rabies or not."

"If an officer catches a rabid dog and finds that the dog has a license tag, then under the injunction the dog must be released," the health officer told Mr. Davis.

"This has done more harm for dogs and dog owners than anything that could possibly have happened," Mr. Davis quoted Doctor Pomeroy as saying.

Hearing on whether or not the injunction will be made permanent will be held before Superior Judge Emmet Wilson Wednesday.

Will Press "Victory"

A meeting for all dog owners has been called by Mr. Lindsay, who secured the injunction, at 8 p. m. Tuesday in the American Legion Hall, 2035 North Highland Avenue, Hollywood.

"This will be an open forum and we will discuss ways and means of making the temporary order permanent," Mr. Lindsay said.—Pasadena *Post*, April 23.

* * *

Assemblyman Boyle Seeks Colden Seat*

Assemblyman Boyle yesterday announced his candidacy for the Democratic nomination in the Seventeenth Congressional District to succeed the late Representative Colden.

Boyle was first elected to the Legislature in 1932 and served three terms, last year being chairman of the Revenue and Taxation Committee. He lives at 1918 West Seventy-third Street, and is a druggist.

By thus announcing for Congress, Boyle ended rumors that he might contest for the Board of Equalization.—Los Angeles *Times*, May 20.

* * *

Parrot Quarantine

Looms After San Francisco Man's Death

Another "parrot quarantine" loomed for San Francisco yesterday, as health officials investigated the death at San Francisco Hospital of sixty-one-year-old Adelbert Henri Houyez, watchmaker, of 3508 Mission Street.

Houyez lived with his pets—a dog, a cat, and "Petit Fille," his parrot, in back of his little shop . For a week or so, he has lamented to neighbors that his parrot, "she is sick!" On Monday, Houyez, too, fell sick and was sent to the hospital, where he died yesterday.

Fearing he was a victim of psitticosis, known as "parrot fever," Health Officer Dr. J. C. Geiger ordered an examination, and had the parrot sent to Hooper Foundation, University of California, for observation. — San Francisco *Examiner*, May 18, 1938.

* * *

Social Work Conference in Pasadena

Twenty-five Hundred Delegates Told Security Act Here to Stay by Federal Agent; Health Discussed

"Social Security is here to stay."

That was the assertion last night of Ewan Claque, director of the Federal Bureau of Research and Statistics of the Social Security Board, as he addressed 2,500 delegates to the California Conference of Social Workers in session at Pasadena.

"The program may in the future he modified in certain respects," he said, "and undoubtedly many improvements have yet to be made. However, essential features as set forth in the Social Security Act have been found by experience to be workable and sound.

California Leader

Richard M. Neustadt, director of the twelfth region of the Social Security Board in San Francisco, revealed California was a pioneer in essential public social services now brought together in the title of Social Security Act.

Health by education instead of medicine was promised by Dr. Harry H. Wilson, Los Angeles physician, who addressed a morning group.

Flaying the public for its "apathy" on health questions, Dr. E. F. Penrose of the University of California pointed to the San Francisco Bay, where sewage was disposed of

*Assemblyman James J. Boyle is the author of the article "As a Pharmacist Views the Proposed California Humane Pound Law," which appeared in the April, 1938, issue of CALIFORNIA AND WESTERN MEDICINE, on page 257, having been read at the Los Angeles County Medical Association's joint meeting of physicians and pharmacists.

without previous treatment. He said, "It's the most unattractive waterfront outside of Asia."

Lynn Mowat, general manager of the local Community Welfare Association, considering social and economic planning, said:

"Separate administration of Los Angeles County by state, county and Federal agencies with their fifty million dollar a year bill is unhearable to the business man because of its inefficiency."—Los Angeles *Examiner*, April 26.

* * *

American Red Cross Meet Opens in San Francisco

San Francisco, May 2.—(UP)—First annual national convention of the American Red Cross, held west of the Mississippi in thirty-five years opened today with three thousand delegates assembled in huge Civic Auditorium here.

Keynote of the convention was sounded by Norman H. Davis, new chairman of the organization, who paid deep tribute at the opening plenary session to the "far-sighted wisdom of the founders of the Red Cross," and added:

"In this troubled world of today the people of our nation and of every nation on the globe have at least one thing in common. Amidst all the strife, they are at least united by one flag—the Red Cross on a white field—which all people love and respect.

"Today," Davis said, "there is no boundary line in the world which erects a barrier to this heroic emblem of humanity."

The American ambassador-at-large, making his first official speech as chairman of the national organization, expressed gratification that the league of Red Cross societies, representative of sixty-two nations, "is becoming a potent influence for good will, understanding and peace between nations." . . .

Mayor Angelo J. Rossi of San Francisco followed Davis to the speaker's rostrum and welcomed the delegates in the name of the city.

"We hail with the greatest pride and satisfaction, the convening here of representatives of a body of over five million of adult members and nearly nine millions of boys and girls—the flower of our coming manhood and womanhood," the mayor said.

Miss Ruth Ellis, of Stockton, spokesman for the Junior Red Cross at the opening plenary session, outlined the activities of the younger group in "building up a common defense based upon friendship and mutual understanding with all."

"On the youth of the world the peace of the future must rest, not on a few, but on all working together for a common end," she said.

James L. Feiser, vice-chairman in charge of domestic operations, said there never has been a time when there was greater need for "Red Cross strength, courage and purpose than today."

"Fortunately, the Red Cross has never been in stronger position," he said. Feiser estimated a total membership gain in the last three annual roll calls of more than 1,500,000. At the end of 1938, he said, the total adult enrollment should be approximately 5,479,000.

"The Red Cross in the world is seventy-five years old this year. It has gone far with its practical idealism since it was launched into the world as a result of the suffering witnessed by Henri Dunant on the battlefields of Europe," he said.—Los Angeles *Evening News*, May 2.

* * *

Functions and Responsibilities of a "Delegate"

A Delegate.—"A delegate is a person appointed and sent to represent another, or others, or to transact business for them; a person who is given authority to vote in a convention, regardless of how or by whom her expenses are paid.

"In the biennial convention of the American Nurses' Association a delegate represents fifty members of the state association of which she is a member.

"She has definite responsibilities and duties.

"She may be instructed by the association as to how to vote on certain questions, or she may not be, but she is expected to have read and studied and to have an intelligent opinion on the business of the convention.

"She is expected to wear her delegate's badge, to attend all business sessions, to be on time and sit through the meetings, and to sit with the other delegates from her state.

"She should report the convention to the unit asking for such report.

"She should be willing to give her wholehearted interest and best thinking to the vital problems discussed in the convention, and to contribute her share in solving them. If she is not willing she should not accept a delegate's credentials. The business of nursing and of nurses is too important not to be taken seriously."—*Minnesota Registered Nurse*, April, 1938.

* * *

Criminal Insane Discussed by Doctors and Lawyers

The subject of the criminal insane, from a medical and legal standpoint, was discussed by attorneys and physicians at a joint meeting of the Los Angeles Bar Association and the Los Angeles County Medical Association last night at the Elks Temple.

Fred Belcher, president of the Bar Association, and Dr. George H. Kress, president of the Los Angeles County Medical Association, introduced various speakers. Medical phases of the question were discussed by Dr. Glenn E. Myers, who said:

"There are many flaws in the present procedure in determining guilt or innocence. I take issue with the contention that if a man knows the difference between right and wrong he is actually responsible for his acts. There are many things which can impair a man's judgment, and the present test is a very weak one. There is much work to be done in this respect. In this work our best legal and medical minds should coöperate."

Frederic H. Vercoe, public defender, spoke on the legal aspects. He said: "Although society, as a whole, does not know what goes on in most of our courts, I feel that society itself is amply protected in the matter of insanity pleas in court.

"Figures taken from the Los Angeles county records for the fiscal year 1936–37 show that out of 4,200 cases, only eighty-six men or women pleaded guilty by reason of insanity. Of the eighty-six I found that forty-two pleas were withdrawn. Twenty-four were found actually insane and of this number twenty-three were sent to asylums. From this I conclude that the present law is working successfully."—Los Angeles *Times*, May 20.

* * *

Dr. J. D. Dunshee to Face Idaho Charge

Phoenix, Ariz., May 24.—(AP)—Dr. J. D. Dunshee, formerly Pasadena health officer and now local health administrator of the State Department of Public Health, was arrested here today on an indictment returned in Boise, Idaho, yesterday, charging "misuse of state funds."

Also named in the indictment returned by the Ada County Grand Jury was Miss Echo Dell Watson, 24-year-old secretary to Dr. H. L. McMartin, Idaho public health director.

Dunshee was state director of public health in California and city health officer of Pasadena before coming here. Several years ago he organized the Idaho public health service.—Los Angeles *Herald-Express*, May 24, 1938.

* * *

Report on Venereal Diseases

(COPY)

TREASURY DEPARTMENT

PUBLIC HEALTH SERVICE

HEALTH OFFICERS' MONTHLY STATEMENT OF VENEREAL DISEASES REPORTED

February, 1938

This statement is issued monthly for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. The following reports were received from state health officers. The figures are preliminary and subject to correction:

	SYPHILIS		GONORRHEA	
	Cases Reported During Month	Monthly Case Rates Per 10,000 Population	Cases Reported During Month	Monthly Case Rates Per 10,000 Population
California	1,755	2.85	1,185	1.93

Monthly statement of venereal diseases reported in cities with populations of 200,000 or over. February, 1938.

Los Angeles, Calif...	618	4.32	381	2.66
Oakland, Calif.	32	1.06	28	.92
San Francisco, Calif.	148	2.21	152	2.27

LETTERS

Concerning incidence of rabies in Los Angeles City and Los Angeles County.

(COPY)

DEPARTMENT OF HEALTH
CITY OF LOS ANGELES

Los Angeles, April 26, 1938.

To the Editor:—As per your request of recent date, I am enclosing herewith the information concerning rabies in animals and humans in the city and county of Los Angeles. These figures are for the years of 1935 to 1938. The report is made up by fiscal and calendar years, respectively. . . .

HYMAN I. VENER, M. D.,
Assistant Epidemiologist.

* * *

*Rabies for Fiscal Years (July 1-July 1): In Los Angeles City and County**

	1935		1936		1937		1938	
	City	County	City	County	City	County	City	County
Dogs	234		368		579			
Cats	3		6		9			
Humans	0		1		1	2 (exclusive of city)		
Miscellaneous:								
Cows	2				4	10		1
Horses			1					
Raccoons			1					
Mules					1	1		
Rabbits					1	1		
Goats						5		
Sheep						1		
Rats						1		

Rabies for Calendar Years: January to December

	1935		1936		1937		1938	
	City	County	City	County	City	County	City	County
Dogs	259	520*	358	806	847	1,730	117	450
Cats						20		3
Humans	1				1		2	

* Totals for county include city cases.

Concerning rabies.†

(COPY)

LOS ANGELES CHAMBER OF COMMERCE

FIFTY YEARS OF SERVICE: "VISION TO SEE, FAITH TO BELIEVE, COURAGE TO DO"

Los Angeles, California,
May 14, 1938.

To the Editor:—We have received your very interesting letter of May 5, with a copy of the May issue of the official journal of the California State Medical Association calling attention to the rabies situation in Los Angeles.

We believe you are handling the matter in a very fair and sensible way. This Chamber is certainly interested in this matter because it is one of those many things which deter people from coming here, not only for a visit, but to locate permanently.

Oftentimes such a situation can be magnified to such an extent back East that we would have an even worse scare than we periodically have when there is an outbreak of foot-and-mouth disease or an occasional outbreak of plague, serious as they are.

We believe the constituted authorities should proceed in every way to eliminate the stray dogs. These dogs appear to be the chief menace to the proper control of rabies.

With appreciation of your interest and with kind regards, I am

Very truly yours,

LOS ANGELES CHAMBER OF COMMERCE.
Arthur G. Arnoll,
Secretary and General Manager.

† See also press items concerning rabies on page 471.

Concerning court decision of interest to doctors, hospitals, and special nurses.

(COPY)

May 3, 1938.

To the Members of the Attending Staff of the California Hospital:

A knowledge of important points may assist you in avoiding liability.

A Recent Case

Plaintiff, a former hospital patient, brought action for $25,000 damages against the doctor, special nurses, and the hospital for alleged hot water bottle burns.

The following facts were brought out at the trial:

The patient entered the hospital for urological surgery. Special nurses were called by a surgeon from District No. 5 list. After surgery he was in extreme shock and a special nurse placed a hot water bottle between his knees. Thereafter a small red area appeared under one leg, above the knee. After leaving the hospital, this area on his leg showed a necrosis. The doctor had quoted a total price of $300 to cover hospital, special nurses, and doctors. The money was deposited at the hospital, which acted as disbursing agent, and paid the doctor $225.

The judge granted a nonsuit as to the hospital and two of three special nurses.

The jury in its verdict decided the injury was due to the hot water bottle placed by the special nurse. The doctor, however, was held for $5,000 damages, as they decided the special nurse was the agent of the doctor due to contract of $300.

Suggestions

We feel these suggestions are important:

1. Do not make flat-rate contracts to include hospital and special nurses.
2. Do not agree to pay the hospital or the special nurses.
3. The patient or relatives should understand that when a special nurse is needed they may choose their own nurse, or that nurses will be called from the register as an accommodation for the patient; and nurses must be paid directly by the patient, or by hospital for the patient, upon patient's written authority.
4. If the patient is to deposit the money at the hospital for payment of doctors and nurses, explain that this is an accommodation only.
5. Let the patients know that the hospital is a nonprofit charitable institution.

Very truly yours,

THE CALIFORNIA HOSPITAL.
Mr. R. E. Heerman,
Superintendent.

Concerning conditions in China.*

To the Editor:—We are still here in Hong Kong trying to learn Chinese. It is slow to acquire, but is interesting. Dr. and Mrs. Stanton May are studying Mandarin, but Mrs. Wagner and I are studying Cantonese. We expect to spend full time in language study for about three months yet. Perhaps I shall go to Canton then to be with Dr. Floyd Bates for a time before he leaves on furlough. I have spent two days with him in Canton. He has been doing a good work there, particularly in tuberculosis, but it has been greatly hindered by the present conflict.

Doctor May and I visited the Hong Kong University and met the dean of the medical faculty and the professors of anatomy and surgery. I plan to attend the surgical rounds of Doctor Digby and his laboratory classes in operative surgery, and if my language study schedule can be arranged, may spend some time in anatomical dissection.

There is much illness among the Chinese, and a person does not wonder at it when he sees their living habits. Their living quarters are small, dirty, and unheated. Some of them cannot afford rooms and sleep on the pavement with a mat for a mattress and a block of wood for a pillow. The weather at times is quite cool and we have had fire in

* From a letter received by the *Journal of the Alumni Association of the College of Medical Evangelists* from Dr. Ernest Wagner bearing the date of January 17. Doctor Wagner was formerly a resident at the White Memorial Hospital, Los Angeles.

our house for over a month. Many of the people look as if they had not had a bath for many months or years. Their eating habits are remarkable. Most of them look undernourished and probably are. Some of their delicacies are snails, cockroaches, beetles, snakes, field mice, and anything that is eatable. I have seen persons walking up the streets selling snails, and others with baskets of cockroaches. One day a fellow carrying a couple of cats in a basket tried to sell us one. I suppose he thought we wanted a feast. Pig fetuses are a great delicacy.

Tuberculosis is very common. I noticed in the paper that there were eighty-one and eighty-two deaths in Hong Kong in two consecutive weeks. At present there is a smallpox epidemic on. A Chinese doctor told us that 80 per cent of the third-class patients have lues. Nasopharyngeal carcinoma is common and in a younger age group than one usually expects carcinoma. Intrahepatic calculi are more common that gall-bladder calculi.

Dr. Harry Miller was here several weeks ago and I saw him do a subtotal thyroidectomy, a lobectomy, and a ligation. He is taking care of a hundred wounded soldiers at the Wuhan Sanitarium in Hankow. Drs. Carl Wang, Herbert Liu, and Samuel Phang work with him. I have seen them and also Dr. Leslie Butka, who is attending the Division Council. Dr. Herbert Honor was through here last week on his way to Manila. He was appalled by the filth, particularly the spitting on the sidewalks. We are more accustomed to it, but it did bother us at first.

There are a large number of missionaries in Hong Kong who have had to flee from China because of the hostilities. Some of them have lost many of their belongings. It is unfortunate to lose a great deal because a mission salary does not allow one to replace things very fast. We are impressed with the uncertainty of the times, but hope that peace will soon be established so that the work can go on. Some of the men will leave their families here and return to their stations.

We have been receiving the *Journal of the Alumni Association* and enjoy reading it even though the news is a month late when it arrives.

There is much more that could be written, but time and space prevent. Give my greetings to the friends at the College of Medical Evangelists.

ERNEST WAGNER, '34.

Concerning United States Public Health Service Booklet on Syphilis.

TREASURY DEPARTMENT
U. S. PUBLIC HEALTH SERVICE

Washington, May 10, 1938.

Dear Sir:

"The Diagnosis of Syphilis by the General Practitioner"* by Joseph Earle Moore, M. D., was written in response to dozens of inquiries and letters from physicians asking for advice on problems of diagnosis.

Case finding and case treatment, writes Doctor Moore, represent the physician's share in fighting syphilis. "On the whole, experience has convinced me that, in spite of all present-day shortcomings, the treatment element is better performed than case finding. . . . That a decrease in the incidence of syphilis is not yet apparent is due, I believe, largely to the fact that so many syphilitic patients pass completely unrecognized until the damage of infection of others or the ultimate breakdown of the individual has already occurred."

This, then, is Doctor Moore's purpose—to give the general practitioner a handy, clearly written manual of diagnosis. Many tables are used throughout to assist the physician in the distinguishing between actual manifestations of syphilis and other diseases with which they may be confused.

"Who is concerned with diagnosis?" asks Doctor Moore. He answers, "Everyone!"—the urologist, gynecologist, dermatologist, ophthalmologist, laryngologist, orthopedist, neurosurgeon, general surgeon, internist, obstetrician, neurologist, psychiatrist, and pediatrician. "In short," he says, "no special branch of medicine, unless it be the allergist (and even he would find syphilis if he deliberately searched for it) is exempt from having to decide, not infrequently but often, whether his patient has syphilis or some other disease."

Doctor Moore's booklet is divided into the following chapters: "The Diagnosis of Syphillis: General Considerations," "The Diagnosis of Early Syphilis," "The Diagnosis of Latent, Prenatal and Congenital Syphilis," and "The Diagnosis of Late Syphilis."

Sincerely yours,

R. A. VONDERLEHR,
Assistant Surgeon-General, Division of Venereal Diseases.

* For sale by the Superintendent of Documents, Washington, D. C. Price, ten cents per copy.

MEDICAL JURISPRUDENCE †

By HARTLEY F. PEART, ESQ.
San Francisco

Compensation for Professional Services Where Patient Has Died, Becomes Bankrupt, Incompetent or Is Under Some Other Legal Disability

Claims Against Decedent's Estates.—Upon the death of a person on whose behalf a physician has rendered professional services, it is necessary to seek compensation from the estate of such deceased person. The California Probate Code specifies in detail the exact procedure that must be followed in such cases. Failure to follow the Code requirements is likely to result in inability to secure payment.

After the death of a person possessing real or personal property, the first step required by law is the probate of such person's will, if there is a will, or application for letters of administration, if there is no will. As soon as an executor or administrator is appointed, a "Notice to Creditors" must be published in a newspaper at least once a week for a period of four weeks. At any time within six months from the date of the first publication, persons having claims against the estate of the deceased may file such claims with the executor or administrator or the clerk of the Superior Court. *Anyone to whom the deceased was indebted who fails to present a claim in the form required by law within this six months' period thereby forfeits his right to payment from the estate.* Hence, it is absolutely essential upon the death of a person from whom compensation is due to ascertain the date of first publication of notice to creditors and file a proper creditor's claim within six months thereafter.

Creditors' claims must be in writing and must set forth with reasonable particularity the nature of the claim. Further, they must set forth the amount due and must be accompanied by an affidavit of the claimant or someone on his behalf that the amount is justly due, that no payments have been made thereon by the decedent which are not credited and that there are no offsets to the claim to the knowledge of the claimant (Probate Code, Sec. 705). After a creditor's claim is prepared and sworn to before a notary public, it must then be presented either to the executor or administrator or the clerk of the Superior Court wherein the estate is pending.

After a creditor's claim is presented to the executor, administrator or clerk of the court, it may then be allowed or it may be rejected in part and allowed in part. It may also be wholly rejected by the executor or administrator. If it is allowed, it is then submitted for approval by the court and, if approved, it must be paid before any assets may be distributed to the heirs, devisees, or legatees. If allowed for only a portion of the claim, or entirely rejected, the claimant may acquiesce or commence action against the estate on the rejected claim within *three months* after the date of service upon the claimant of notice of rejection (Probate Code, Sec. 714). If the executor or adminis-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

trator fails to act on the claim, such neglect is deemed equivalent to a rejection (Probate Code, Sec. 712).

Bankruptcy Claims.—If a patient either voluntarily or through action of creditors is adjudged bankrupt after professional services have been rendered, but before payment therefor, it is necessary for the physician, if payment is desired, to present a claim against the patient's estate in bankruptcy. A claim in bankruptcy must be established by filing with the trustee or referee in bankruptcy appointed by the court a written statement under oath, signed by the claimant, setting forth the nature of the claim, the consideration therefor (*i. e.*, medical services rendered, consisting of, etc.), whether or not any security is held by the claimant and that the sum claimed is justly owing from the bankrupt to the claimant (Bankruptcy Act, Sec. 57, subdv. A).

Forms for establishing proof of claim in bankruptcy have been promulgated by the Supreme Court of the United States and in making proof the form prescribed by the Supreme Court should be used. Claims against a bankrupt's estate *may* be filed at any time within one year after the adjudication of bankruptcy (Bankruptcy Act, Sec. 57, subdv. N), but should be filed as soon as possible after notice is received of the bankruptcy petition. The earlier a claim is filed the better, because prior to filing of a claim the creditor has no right to participate or share in the bankruptcy proceedings.

If a person goes into voluntary bankruptcy and lists as one of his creditors a physician who has performed professional services on his behalf and such physician does not, within one year from the date of adjudication of bankruptcy, file a claim in the proper manner, all legal right to secure any compensation for such services is lost.

Estates of Incompetent Persons.—When professional services are rendered for a person who is or subsequently becomes incompetent, it is necessary to look to the guardian of such person's estate for compensation. In using the word "incompetent," we are using it in the sense defined in the Probate Code, which is:

> The phrase "incompetent" shall be construed to mean or refer to any person, whether insane or not, who by reason of old age, disease, weakness of mind or other cause is unable, unassisted, properly to manage and take care of himself or his property, and by reason thereof is likely to be deceived or imposed upon by artful or designing persons.

Such a person is supposed to be under the care of a guardian of his person and estate, appointed by the Superior Court (Probate Code, Sec. 1460). Professional services rendered to such a person to be compensable should be rendered at the request of the guardian, if one has been appointed by the Superior Court, and if services are so rendered the guardian is responsible therefor, but only out of the estate of the incompetent. That is to say, a guardian may not be required to resort to his own resources to pay for professional services rendered unless he has previously agreed so to do.

Compensation for Services Rendered to Minors.—When services are rendered to a person under the age of twenty-one years at the request of either parent, or, if the parents be dead, a guardian appointed by the Superior Court, compensation therefor is recoverable from such parent or guardian. If professional services are rendered to a minor without the direction or authorization of his parent or guardian, it is possible that compensation therefor may be recoverable from such minor. Civil Code, Sec. 36, provides that:

> A minor cannot disaffirm a contract, otherwise valid, to pay the reasonable value of things necessary for his support, or that of his family, entered into by him when not under the care of a parent or guardian able to provide for him or them; provided, that these things have been actually furnished to him or to his family.

Under this section it must be noted that:

1. An agreement by a minor alone to pay for professional services rendered to him may be enforceable against him;
2. Whether enforceable or not as against the minor, it is not enforceable against his parents (unless they expressly or impliedly request the services), and hence may only be collectible if such minor has property of his own; and
3. A contract on the part of a minor to pay the reasonable value of things necessary for his support is only valid and enforceable when he is not under the care of a parent or guardian able to provide for him.

SPECIAL ARTICLES

ALAMEDA COUNTY INSTITUTIONS COMMISSION*

Copy of Ordinance No. 250 (Adopted in 1932)

An ordinance relating to the powers and duties of the Alameda County Institutions' Commission, and repealing Ordinance No. 208, entitled "An ordinance creating the Alameda County Public Health Center Board and Prescribing its powers and duties pursuant to the provisions of Section 13 of the charter of the county of Alameda."

The Board of Supervisors of the County of Alameda, State of California, do ordain as follows:

Section 1. Subject to the direction and control of the Board of Supervisors, the Alameda County Institutions' Commission shall have the following powers and duties in addition to those which it now has:

(*a*) It shall organize, supervise, coördinate and administer all of the medical and/or dental services, including the supply of glasses, artificial eyes, limbs, braces and such other appliances as may be required and furnished to the dependent poor and/or indigent sick on behalf of the county of Alameda.

(*b*) It shall determine the services to be rendered through hospitals, health centers and/or clinics throughout the county and it shall determine the location of such clinics and health centers as may be necessary and shall establish such clinics and health centers which may be necessary to supply the service to the indigent sick or dependent poor of the county.

(*c*) It shall direct and supervise the county health and disease prevention program and shall coöperate with all of the agencies, both public and private, engaged in such work in the county of Alameda. It may recommend to the Board of Supervisors contracts under which the county may contract with incorporated areas to assume public health work throughout the county, and when such contracts have been made it may establish such organization as may be required to carry out the prevention and control of disease throughout Alameda County.

(*d*) It shall supervise the expenditure of all funds appropriated by the county of Alameda for said medical and/or dental services and/or prosthetic appliances for the prevention and control of disease and for promotion of public health.

Section 2. All persons who furnish and all county employees employed in agencies and institutions which furnish said medical and/or dental and/or prosthetic appliances shall be appointed, promoted, and removed by the Board of Supervisors upon the recommendation of said Commission, subject to the laws and ordinances relating to Civil Service.

Section 3. The Medical Director shall be the executive officer of the County Institutions Commission and be in immediate charge of all of said persons, agencies and institutions furnishing said medical and/or dental and/or prosthetic appliances, and shall perform his duties under the supervision of said commissions.

Section 4. Ordinance No. 208, entitled "An Ordinance Creating the Alameda County Public Health Center Board and prescribing its powers and duties pursuant to the provisions of Section 13 of the charter of the county of Alameda" is hereby repealed; provided, however, that the persons occupying the positions designated as Items 1K-1 to 1K-7, inclusive, and as Items 1V-1 to 1V-2, inclusive, in Ordinance No. 247 of this county shall continue to hold their respective positions in accordance with the terms of said Ordinance No. 247, until such time as this service is reorganized by said Commission, subject to the laws and ordinances relating to Civil Service, and the persons oc-

* See editorial comment in this issue, on page 396.

cupying said positions shall from the time this ordinance takes effect be under the supervision and direction of said Commission and the Medical Director, and said positions shall, when vacancies occur therein. be filled by appointment of the Board of Supervisors upon the recommendation of said Commission.

Section 5. This ordinance shall take effect and be in force immediately. This Board finds and declares this is an ordinance for the immediate preservation of the public peace, health, and safety, for the reason that the county of Alameda is confronted with a grave problem of unemployment and that it is necessary in order that the unemployed may receive proper medical and other relief and the public peace, health and safety be maintained, that this ordinance shall go into effect immediately. Before the expiration of fifteen (15) days after its passage it shall be published with the names of those voting for and against the same for one week in the Oakland *Post-Enquirer*, a newspaper published in said county of Alameda.

Adopted by the Board of Supervisors of the county of Alameda on the twenty-third day of August, 1932, by the following vote:

Ayes: Supervisors Davis, Richmond, Staats, and Chairman Hamilton—4.

Noes: Supervisors, none.

Absent: Supervisor Heyer—1.

WILLIAM J. HAMILTON,
Chairman of the Board of Supervisors of the County of Alameda, State of California.

Attest:

G. E. GROSS
County Clerk and Ex-officio Clerk of the Board of Supervisors of the County of Alameda, State of California.

MIGRATION OF LABORERS TO CALIFORNIA*

The Los Angeles office of the United States Farm Placement Service has issued a report on outside people seeking manual employment, from the drought states, who have entered California through border checking stations in 1937. The source of the data is the Bureau of Plant Quarantine, Department of Agriculture, of the State of California, through the office of the Farm Security Administration, of the United States Department of Agriculture, San Francisco.

The drought states are specified as Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, Mississippi, Oklahoma, South Dakota, Texas, Utah, Wisconsin, and Wyoming. The report shows that out of 104,976 passengers who entered California by automobile from all states, 78,332 were from the nineteen states designated as drought states. This indicates that 26,644 individuals, seeking manual labor, entered from the remaining twenty-nine states. From Oklahoma came 21,709 individuals seeking manual labor; from Arizona 10,613; from Texas 8,723; from Arkansas, 7,232, from Missouri 6,316; from Kansas 4,484. From Oklahoma, Texas, Arkansas, Arizona, Missouri, and Kansas came a total of 59,077 of these migratory laborers—75.4 per cent of the entire number. The numbers of these workers segregated by single men and by families for the nineteen drought states are as follows:

Drought States	Single Men	Families	Totals
Arizona	1,045	9,568	10,613
Arkansas	660	6,572	7,232
Colorado	733	2,969	3,702
Idaho	497	1,515	2,012
Iowa	270	754	1,024
Kansas	688	3,796	4,484
Minnesota	233	475	708
Missouri	681	5,635	6,316
Montana	348	754	1,102
Nebraska	765	2,259	3,024
Nevada	308	615	923
New Mexico	263	2,417	2,680
North Dakota	171	663	834
Oklahoma	1,755	19,954	21,709
South Dakota	206	958	1,164
Texas	681	8,042	8,723
Utah	347	715	1,062
Wisconsin	110	251	361
Wyoming	153	506	659
Totals	9,914	68,418	78,332

Out of the total of 78,332 migratory laborers who entered the state last year, 73,692 were white; 3,076 were Mexican, 1,126 were colored; 246 were Filipino, and 192 were members of other races.

It is apparent, therefore, that a preponderance of these workers were white people from the South Central states. It is also apparent that the migration of individuals seeking manual labor who migrated to California from other states is almost negligible as compared with the migration of such people from the drought states.

It would seem that most of these 78,332 upon arrival in California settled in the lower San Joaquin Valley. It is in that section of the state where the most acute health problems associated with migratory laborers have been discovered.

The report as released by the Farm Placement Service confirms the informal reports that have been received from the agricultural districts of California. Heretofore, there have been no official statistical summaries issued. This report, however, provides material upon which to base opinions and decisions relative to the proper handling of the health of migratory laborers and to institute proper measures for control of migration into California.

* * *

Pomeroy Tells Big Jump in California Relief Load

Sacramento, May 24.—(UP)—Failure of the federal housing program to stimulate residential building, continued influx of migratory workers and widely publicized advantages of California have combined to make an alarming increase in the state relief load, State Relief Administrator Harold Pomeroy said today.

Pomeroy pointed to the unprecedented doubling of the relief load in the San Joaquin Valley as an example of what faces California taxpayers.

"The 1938 unemployment situation is as bad as during the depths of the depression," he declared.

Figures cited by Pomeroy included:

There are 7,500 to 10,000 persons entering California each month, many without adequate funds or gainful occupation.

Six Per Cent Increase

The total load of the State Relief Administration, Works Progress Administration and Farm Security Administration has jumped 6 per cent from 154,000 cases at this time last year to 164,500 this month.

The five San Joaquin Valley counties of Fresno, Madera, Kern, Merced, and Tulare have a total of 16,880 relief cases as compared to only 6,325 a year ago.

The WPA is carrying a larger load each week and is now up to 108,000 cases, about the same as last year.

Despite housing programs, residential building was down 22 per cent in March as against the same month last year.

The *Farm Security Administration*, entering the California relief picture for the first time this year, already has 5,720 cases in the five counties.

Pomeroy explained that California persons needing relief probably are supported more adequately than in any other state. In addition to an average relief allowance of $34.60 per month, second highest in the nation, an average of $3.90 in surplus food commodities was distributed to 20,000 relief cases during April and an average of $9.18 per family was distributed in relief clothing. More than 12,500 women are employed on sewing projects.

Fall Back on Relief

"Seventy-five per cent of migrants entering California come from the states of Arkansas, Oklahoma, Texas, New Mexico, and Arizona, where relief allowances average $4.09 to $8.19 per month." Pomeroy said. "To these workers, California is a land of plenty when you consider that state relief averages start with Mississippi at $3.18 per month, a total of $31.42 less than offered here.

"These migrants often are unable to find steady work, particularly in agriculture, and fall back on relief rolls."

* See also items on pages 397 and 460.

Pomeroy declared unemployment benefits removed 866 persons from the relief rolls in April.

Measures being taken to rehabilitate single unemployed men in cities were explained by the director. Mountain camps have been established where men are given outdoor work until they are physically able to accept WPA or private jobs.

Pomeroy said of the 4,000 single men on relief in San Francisco, 2,500 were physically unable to take jobs. In addition, 12 per cent of the men have venereal disease and are given free and compulsory treatment. Only free board and lodging is offered, but hundreds of the men have been turned back into paying jobs, he said.—Los Angeles *Evening Herald-Express*, May 24, 1938.

* * *

Kern County Migrant Relief Rush Stirs Protest

With Thirty-six Thousand on Rolls, Move Starts to Stem Tide: United States Administration Method Hit

Bakersfield, May 24.—(Special to The Los Angeles Examiner.)—With 36,000 persons on various relief rolls in Kern County, citizens have launched a movement to stem the tide of an inrush of penniless farm workers to this area, where workers already number three for every one available farm job.

A citizens' committee of sixty, which has been studying the problem, decided today to appeal to the Federal Government to stop administering relief as it is now being administered by the Farm Security Administration to any migrant who applies for aid. The committee holds that this ready relief acts as a lure and is chiefly responsible for continued arrival of new flocks of penniless families into the San Joaquin Valley, particularly into Kern County.

At Sources

The contention will be made by the committee that the federal agency should discourage this migration at its sources instead of providing, in effect, this encouragement. The ever-increasing influx, curtailment of crop acreages, and the activities of a half-dozen relief agencies have made the situation here one which is threatening the county's financial structure, officials declare.

The migrant labor and relief problem has become so pressing that it imperils every working man and woman, their homes and livelihood, in the opinion of the citizens' committee. . . .

5,179 Seek Jobs

Robert W. Evans, manager of the California State Employment Service, told the group that there are now 5,179 people on file in his office as seeking work, and that with migrants and others not registered the true figure of the unemployed is more than 10,000.

Welfare Director Skelton reviewed the growth of the county's relief budget from $74,000 ten years ago to $800,000 this year, with the prospect of $1,300,000 being required from the county alone in the coming fiscal year.—Los Angeles *Examiner*, May 25, 1938.

LOS ANGELES COUNTY HOSPITAL*

(Continued)

Cut in Hospital Load Sought

Supervisors Discuss Limitations to Reduce Tentative Budget Total

Prospect of establishing limitations on the General Hospital case load, now averaging 2,613 cases, was discussed recently by the Supervisors as a hospital budget of $5,642,359 for 1938-1939 was given tentative approval.

The budget represents an increase of $422,930 over the $5,219,429 allowed in 1937-1938, but the increase is subject to possible further reduction of $111,972, representing group advance salary increases.

WILL OPPOSE ITEM

Chairman Jessup and Supervisor McDonough both declared they will oppose the $111,972 item, so that the hospital budget may likely be reduced to a net increase of $310,958 over last year's budget allowances.

Furthermore, as expenditures in 1937-1938 exceeded by $90,000 budget allowances, the actual hospital increase over last year's expenditures, if salary increases are denied, will be $220,958.

Setting of a "ceiling" for General Hospital cases was discussed, but action was deferred on whether the present case load, or the 3 per cent increase asked by Superintendent Everett Gray, will be granted. The 3 per cent would allow an average increase of seventy-eight cases.

OLIVE VIEW BUDGET

In discussing the Olive View Sanatorium budget with Superintendent Arthur J. Will, however, the Board set a case load for tuberculosis patients of 2,017.

Shift of part of the hospital load on Los Angeles City was discussed when Deputy Counsel McFadden informed the Board he believed General Hospital need not accept the city's contagious nonindigent cases except at city expense.

TOTALS APPROVED

General Hospital budget totals tentatively approved were:

Salaries and wages, $4,781,296, up $443,522.

Maintenance and operation, $814,215, up $25,510.

Capital outlay, $46,848, down $46,102.

Olive View Sanatorium:

Salaries and wages, $1,016,977, up $66,718.

Maintenance and operation, $319,005, up $192,160, all of which will be met by revenue.

Capital outlay, $30,284, down, $64,859.

Total, $1,366,266, for an increase, after deduction of revenue, of $1,019.

* * *

Supervisor Jessup Urges Manager for Los Angeles County

Only Way to Curb Mounting Expenditures, Says Chairman of Board of Supervisors

Would Not Be Legislator: Plan Gives Administrative, Financial Problems to One Man; Will Launch Drive

Government costs for Los Angeles County, with a base tax rate which has risen from 88 cents to $1.41 since 1930, with even higher expenditures looming for 1938-1939, can be curbed only by operating under a county manager as business executive.

Roger W. Jessup, Chairman of the Board of Supervisors, made this statement yesterday as he and his colleagues began the task of attempting to cut the county's current preliminary budget of $87,905,741 by departmental slashes.

System Assailed

"The present system makes it possible for any extravagant member of the Board to dodge individual responsibility and at the same time make it virtually impossible for economically minded members to produce results."

Uttering this declaration, Jessup stated handling of county financial and administrative problems "should be placed in the hands of one man," with the five supervisors retaining legislative authority.

Jessup indicated he would immediately launch campaign to achieve his plan, which would entail material changes in the county charter and existing state laws.

Yesterday, the Supervisors considered preliminary budget requests of fourteen county departments.

Budget for principal departments as allowed were: Superintendent of Schools, $146,585, an increase of $5,251 over last year; County Clerk, $508,845, an increase of $15,627; Juvenile Hall, $263,979, increase of $7,849; livestock inspector, $83,704, increase of $17,270, and purchasing department, $77,675, increase of $5,713.—Los Angeles *Examiner*, May 6.

* * *

Medical Care Bill Change Expected: Supervisors Back New Hospital Plan

Ability to Pay to Be Factor

Revision Result of Medical Society Complaint

Los Angeles, May 3.—(CNS)—Revision of the method of billing patients at the General Hospital, as a result of the recent attacks made upon the system by Dr. George H. Kress, President of the County Medical Association, were virtually assured today when Supervisor Herbert C. Legg obtained support of Supervisors John Anson Ford and Leland M. Ford in a proposal for modification.

Under Legg's plan, the ability of the patients to pay the time of hospitalization would decide whether he should be billed for the services.

* For other articles dealing with the Los Angeles County Hospital see CALIFORNIA AND WESTERN MEDICINE, as follows: February, 1938, pp. 73 and 78; March, pp. 156 and 216; April, pp. 234 and 297; and May, pp. 309 and 383. In this issue, see page 395.

At present the charities department maintains contact with patients who are rendered hospitalization service and should they at any time be deemed able to pay for treatment, they have the alternative of voluntarily discharging the obligation or being sued in court.

Tells Kern Decision

Legg said that the much-discussed Kern County decision that required uniform billing of county hospital patients definitely "fixes the time for determining ability of the patient to pay as the time when the treatment is rendered and the county should not hound the unfortunate man or woman the rest of his life for payment of these bills."

He said he had asked the county counsel for an opinion as to legality of the proposed modification of billing and collection methods.

Recommendation Due

Supervisor Gordon L. McDonough, Chairman of the Institutions Committee of the Board, said the Medical Advisory Committee of the Hospital had the question under consideration and would make a recommendation to him within a few days.

Supervisor Leland M. Ford said:

"I, too, believe we should not work a hardship on the needy by hounding them for years after they leave the hospital, but of course we should take every precaution against chiselers."

Supervisor John Anson Ford urged that when the changes were made they should include provisions for billing of patients in accordance with their circumstances instead of under the present standardized schedule of charges.—Pasadena *Star-News*, May 3.

* * *

City Urged to Rent Tuberculosis Hospital

Tentative steps toward accepting the offer of private owners to erect a 940-bed tuberculosis hospital and lease it to the county for $108,000 a year were taken by the Board of Supervisors yesterday.

Although delaying definite decision on the proposal, the Board instructed Rex Thomson, Superintendent of Charities, to make a budget request of $468,000 for the project.

The hospital would be erected adjacent to Olive View Sanitarium. Its construction would enable the county to obtain $130,000 a year in tuberculosis aid from the state, officials said.

Marshall Stimson, representing the private owners, said the county would only have to install utilities and equipment, estimated to cost $366,000.

The Board also ordered included in the preliminary budget an item of $45,000 for erection of a twenty-bed smallpox isolation hospital on the General Hospital grounds.—Los Angeles *Times*, April 27.

* * *

Infantile Isolation Building Urged by General Hospital Head

Erection of an isolation hospital at a cost of $1,125,000 to care for patients suffering from infantile paralysis was recommended to the Board of Supervisors today by Everett J. Gray, Superintendent of the Los Angeles County General Hospital.

Gray also recommended that a twenty-bed smallpox hospital be erected, but made no estimate of the cost.

He proposed that both buildings be erected on the General Hospital grounds, south of the present building.—Los Angeles *Herald-Express*, April 22.

* * *

Cancellation Held Void by High Court

Lien Law Not Retroactive

The California State Legislature exceeded its authority in canceling millions of dollars in liens and mortgages taken as surety for relief extended to the needy aged.

This was the ruling of the State Supreme Court today in backing up the stand of the Los Angeles County Supervisors that the Board itself would be held liable for the cancellation of surety deeds should the law prove to be unconstitutional.

Chairman Roger Jessup challenged the constitutionality of that *retroactive part of the law which would cancel liens and mortgages taken prior to last September 1.* This position was upheld by the court.

No attack was made on that part of the law which says that no further lien or mortgage may be taken on property owned by the needy aged, and the court upheld this phase of the legislatioon.

Thousands of persons in the county whose property still has liens against it because of the court's action were reassured that there will be no foreclosure action by the county.

Supervisor Herbert C. Legg said: "The county will use its liens and mortgages only in filing the claims against estates of old-age pensioners after their death in the exact amount of relief that has been extended them."

County Superintendent of Charities Rex Thomson said the county abandoned its practice of taking such liens last September 1, when the law became effective.

Basis of the test case was the refusal of Jessup to cancel twelve mortgage releases, carefully selected to cover every type of case in which liens had been taken in past years.

In Los Angeles County alone there are 400 such liens and mortgages, representing an indebtedness of $960,000 against property valued at $3,500,000.—Los Angeles *Evening News*, May 3.

* * *

County Seeks Way to Curb Hospital Load

Board Orders Study of Budget and Asks Opinion on Banning Communicable Disease Cases

Strict limitation of the number of patients treated in the county's General Hospital as a means of preventing further major increases in costs was ordered studied by the Board of Supervisors yesterday as they allocated $5,742,359 for the institution's 1938-1939 expenditures.

Tentatively granting a $311,000 increase for the coming year above the 1937-1938 budget, the officials declared drastic measures will have to be considered as a means of halting constantly mounting upkeep of the institution.

May Bar Cases

The Supervisors also ordered County Counsel John H. O'Connor to render an opinion on the duty of the county to admit to the General Hospital nonindigent persons, resident in incorporated cities here, who are afflicted with communicable diseases.

Barring of such tuberculosis, smallpox and other communicable disease victims from the General Hospital would compel Los Angeles and others of the forty-four incorporated municipalities in the county to erect their own communicable disease hospitals.—Los Angeles *Examiner*, May 20.

RABIES

1913 Quarantine Statute Not Repealed by 1921 Licensing Law, Rules Judge Emmet Wilson

Elsewhere in this issue appear some press items concerning the rabies situation in Southern California. The following court opinion appeared in the Los Angeles *Daily Journal* of May 18, and should be of interest:

Stating that "A license tag is not an amulet which will immunize against disease," Superior Judge Emmet H. Wilson recently sustained the orders of the State Board of Health quarantining dogs, whether licensed or unlicensed, which were recently issued.

He held that the statute of 1913 authorizing the issuance of quarantine orders was not repealed by the dog license act of 1921 because neither was repugnant to the other and that when two statutes relating to the same general subject are not incompatible with each other, effect must be given to both.

The opinion follows:

Opinion, No. 427355

In the Superior Court of the State of California, in and for the County of Los Angeles.

The Tailwaggers Foundation, a Corporation, Plaintiff vs. Dr. J. L. Pomeroy, County Health Officer, et al., Defendants.

For Plaintiff—James B. Fredericks.

For Defendants—J. H. O'Connor, County Counsel, and Beach Vasey, Deputy County Counsel, Ray L. Chesebro, City Attorney, Robert H. Patton and William Christensen, Deputies City Attorney.

Amici curiae on behalf of defendants—U. S. Webb, Attorney-General, and Bayard Rhone, Deputy Attorney-General.

This action was commenced for the purpose of obtaining an injunction restraining the enforcement of two orders issued by the State Board of Health quarantining dogs, one including a large portion of the county of Los Angeles with the exception of territory within certain incorporated cities,

and the other covering the city of Los Angeles. The orders purport to have been issued pursuant to the quarantine act (Stats. 1913, p. 783, ch. 369; 1 Deering's Gen. Laws, p. 143, act 360) and require all dogs, whether licensed or unlicensed, to be confined within an enclosure or on a leash.

The plaintiff corporation, alleging that it consists of 4,500 dog owners who have procured licenses for their dogs as provided by law, argues that the quarantine act has been repealed by implication, in so far as licensed dogs are concerned, by a later statute relating to the licensing of dogs. (Stats. 1921, p. 1306, ch. 757; am. Stats. 1929, p. 1881, ch. 852; 1 Deering's Gen. Laws, p. 171, act 384.)

The prevalency or nonprevalency of rabies among dogs is not at the present time in issue. It will, therefore, not be necessary to consider any of the affidavits relating thereto or those giving the numbers of licensed and unlicensed dogs that have been found to be afflicted with rabies. A license tag is not an amulet which will immunize against disease. The need of protection to human beings from peripatetic dogs is no less if the dogs be licensed than if unlicensed.

The only question in the case is one of statutory construction. It is not contended that the quarantine orders were not regularly issued pursuant to the requirements of the statute of 1913, or that the orders are invalid or unenforceable, except upon the theory that said statute has been repealed by the statute of 1921 or by the amendments thereto.

It is a rule of statutory construction that the enactment of a law operates to repeal by implication all existing laws inconsistent with or repugnant to the latter, without a formal repealing clause, and where two acts passed at different times are not in terms incompatible with each other, yet if it is clearly evident that the last was intended as a revision of or a substitute for the first, it will repeal the first to the extent in which its provisions are revised or substituted. Another rule of construction is that repeals by implication are not favored and that the repugnancy of one statute to another should be very clear to warrant the court in holding that the one later in time repeals the older when it does not in terms purport so to do. Two statutes must be so construed, if possible, as to give effect to both if it can be done without destroying the evident intent and meaning of the later act.

The act of 1913 has for its purpose the prevention of the introduction of animal diseases dangerous to human beings into portions of the state not infected and to that end authorizes the State Board of Health to establish a quarantine against all animals living within such area as should be specified in the quarantine order. This act is a health and safety measure designed to protect human beings from rabies and other animal diseases. The act of 1921 prohibits the running at large of any dog unless it wears a license tag issued by the proper licensing authority of a city or a county. Nothing in this statute or in any of the amendments thereto purports to be a health measure, and the same contain no provisions relative to the prevention or eradication of disease. It is strictly regulatory, requiring all dogs to be licensed and providing for the impounding of any dog found running at large without a license tag. There is no manifestation of any intent on the part of the legislature to repeal or to modify the health and safety regulations contained in the statute of 1913. The preservation of the public health is one of the most important governmental functions, and the rule against repeal by implication is particularly applicable where the result of such repeal would be to impair a settled prerogative of government. (*County of Inyo* vs. *Hess*, 53 Cal. App. 415, 200 Pac. 373.) Section 4 of the act of 1921, as amended in 1929, declaring it to be unlawful to kill or to impound a dog, the owner of which has complied with that act, "except as otherwise provided herein," cannot be construed as referring to or repealing any part of the act of 1913, but must be held to relate to those portions of the statute of 1921 which, in the cases therein mentioned, permit and authorize the killing of a dog by a person other than the owner.

It is true that dogs are property and that the owners have a property right therein, but, like other property, they must be kept by their owners in such manner as that they will not become a menace to other animals or to human beings.

The act of 1913 being in full force and effect and no claim having been made that the quarantine orders are unnecessary or that the same are not in accord with that act, it is ordered that the several demurrers to the complaint be and they are sustained without leave to amend, the application for a preliminary injunction is denied, the temporary restraining order is dissolved, the order to show cause is discharged, and judgment is ordered in favor of the defendants.

Dated the seventeenth day of May, 1938.

EMMET H. WILSON, *Judge.*

Chemicals Ineffective Against Virus Infections.—The outlook for chemical warfare against virus diseases such as infantile paralysis, influenza, and encephalitis is not encouraging, in the opinion of Dr. Earl B. McKinley, Dean of George Washington University Medical School.

Attempts by himself and his associates, Jean Sinclair Meck and Ellen Gray Acree, to destroy or check the growth of five disease-causing viruses by three chemicals—prontosil, prontylin, and sodium sulphanilyl sulphanilate—under conditions such as would be met in treating patients, all failed, Doctor McKinley reported at the meeting here of the Federation of American Societies for Experimental Biology.

The reason why the chemicals are ineffective against virus infections is, Doctor McKinley suggested, because viruses, unlike bacteria, get inside the cells of the body. The body cells seem to protect the virus from attack by chemicals. Bacteria, such as streptococci, are kept out of the cells and ordinarily occupy the spaces between body cells. Here they are easily attacked by the chemicals which hold the bacteria in check until the germ-fighting cells of the body are able to overcome them.

Clue to Curative Effect.—A clue to why and how sulfanilamid achieves its spectacular cures has been found by Drs. H. A. Davis, L. C. Harris, Jr., and H. C. Schmeisser of the University of Tennessee.

The chemical, it appears from their studies, activates the body's reticulo-endothelial system. Included in this group are cells of the spleen, liver, lymphoid tissue, and the macrophages of the general tissues of the body.

The exact action of sulfanilamid and the related prontosil has been something of a mystery, since the chemicals have not shown much direct germ-destroying power themselves. Solutions of the chemicals put in a test tube with disease germs did not kill the germs to any extent, even though the chemical, when given as medicine, cured the disease caused by the germs.

The clue was found by study of the tissues of white rats that had been given daily injections of the chemical over a period of three months. . . .

A new chemical remedy for burns which may prove superior to the now widely used tannic acid treatment was reported by Drs. K. K. Jones, R. W. Vance, and Quin De Marsh of Northwestern University Medical School.

The chemical is sodium hexametaphosphate. A solution of it prevents infection of burns and other tissue that has lost its skin because of injury. This chemical combines with the fluid oozing from the skinned tissues to form a film that is moist, firm, flexible, and that prevents the growth of bacteria or disease germs.—*Science Service.*

Adie's Syndrome.—Kennedy and his associates call attention to a symptom-complex which has repeatedly been mistaken for syphilis of the central nervous system. Ordinarily it consists merely in tonic reactions of one or both pupils and in the absence of one or all of the deep tendon reflexes. In general, the syndrome has been found in healthy young females without other signs of organic nervous disease. It is generally symptomless except for a not uncommon photophobia on passing from a dark to a light place. The ratio as to sex is about five females to one male. Many of the patients give evidence that the ocular signs have been present since childhood; they have lived many years without the appearance of any other signs or symptoms. Adie restricted the syndrome to those cases in which there are no other neurologic signs and to persons who are otherwise in good health. To report the syndrome in association with every sort of disease is to widen its significance progressively until it loses all meaning and value. Vasomotor instability is also frequently noted in patients presenting this syndrome. Adie's syndrome is a symptom-complex which closely simulates syphilis of the nervous system and is not syphilis. Knowledge of the Syndrome is indispensable to every physician who undertakes to diagnose syphilis of the central nervous system.—*Archives of Ophthalmology.*

In all things relating to disease credulity remains a permanent fact uninfluenced by civilization or education.—Osler.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 6, June, 1913

From Some Editorial Notes:

Legislative Enactments.—Quite a number of public health bills that did not touch upon the "administrative policy" one way or the other, were passed. Whether they will be signed or not of course remains to be seen. When the thirty-day period is over and things are finally settled, they will be discussed. It may be said, however, that all the bills prepared by the Tuberculosis Commission (they will be found in the report of the Commission published in this issue) were passed. Nearly all the bills proposed by the State Board of Health, we understand, were also passed. Later on it will be possible to give some idea of the nature of such of these bills as become laws and what may be expected to result from them.

* * *

New State Insane Asylum.—The legislature, which might well be called the latest experiment in state insane asylums, has adjourned with a record never equaled anywhere at any time. It is conservatively estimated that it will take California at least fifty years to get over the damage done in the last four months. The philanthropic suggestion of Mr. Johnson in his gubernatorial message to the assembled lunatics when they began their banderlog play last January to the effect that any physician licensed to practice medicine anywhere in the United States ought to be given a license in California without further formality, had its due effect; some thirty bills amending the Medical Act or creating new medical laws were introduced; they were nearly all bad; destructive. The prize freak that finally passed, in spite of protests from every school of medicine and from every element of the community, was Senate Bill 813. It is a heart-breaking task to discuss it; it will be found printed in full on another page. It is seldom that a supreme court says anything that is good; but the Supreme Court of California went out of its way to say that it was a wise provision of the legislature (of 1901) to make the standard of the Association of American Medical Colleges the minimum standard for medical education in this state because it is a flexible standard. This "wise provision" the legislature of 1913 has eliminated! There are some parts of this bill which may seem good to you as you read it; but do not be fooled—it is as full of holes and bugs as an infected sponge. Whether the Governor will sign the bill or not, is now the all-important question.

* * *

Insurance Companies' Lies.—Nearly all the insurance companies that are writing indemnity insurance for physicians—insurance against malpractice suits—have been writing and continue to write lies about the Medical Defense of the State Society. And when they do not write absolute and actual lies, they write such clever half-truths that the idea conveyed is just as distorted as though a direct lie had been stated. . . .

* * *

Lack of Support.—. . . If you would take the trouble to look through the advertising pages of your own JOURNAL you would find that nearly everything you may want is therein advertised; and if you would deal with your advertisers—and let them know that you are doing so and taking an interest in them—such an answer would not have been received in this particular case; the advertiser would have continued to help support your JOURNAL. Everything you see in the advertising pages of your JOURNAL is good—remember that. Also remember that the more interest you take in your advertisers the more interest they will take in your JOURNAL and the better journal you will have. But

(Continued in Front Advertising Section, Page 13)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Hospital routine of an alleged 'abortion mill' at 327 Fillmore Street, was suddenly disrupted yesterday by police raiders. Nine women patients, one of them in bed, were discovered in the place, where a thriving business in illegal surgery has been conducted over a considerable period of time, officers said. Inez L. Brown, well known to police, was taken into custody as the hospital operator, along with Margie Silver, assertedly employed there as a nurse, and booked on a charge of criminal abortion. . . . The Brown woman, volubly protesting that her establishment was only a massage parlor, at first refused admittance to a rear apartment on the third floor. Finally, changing her mind, she showed police into a tiled 'laboratory' or operating room, where instruments and medicinal solutions were found in abundance. She was arrested as the alleged owner of equipment in an abortion hospital raided at the same address in July, 1936, police records revealed. The entire third floor of the building was furnished in semi-hospital style, with eleven beds. Margie Silver, the alleged nurse, was taken to police headquarters for further questioning. (San Francisco *Examiner,* May 5, 1938.) "Inez Brown of abortion mill notoriety has for two years been fighting a $72,500 federal income tax claim, files of a Superior Court lawsuit disclosed today. At one stage of the tax dispute, she was threatened with federal indictment for fraud and was saved by prompt action of an attorney who flew to Washington, pleadings of the lawsuit assert. Assets of the 47-year-old woman, who told raiding police at her Fillmore Street abortion mill last week she was 'just a poor woman trying to rent some rooms,' were listed at $202,956.80 in 1936. The Government claims she failed to file a return on two-thirds of her income between the years 1928 and 1935. Such income as she did report she listed for 'nursing services,' it was learned. Treasury Department agents are checking her income tax returns for the years 1936 to 1938 inclusive, it was reported, as a result of disclosures last week that her income from abortions has reached as high as $550 daily. Mrs. Brown is scheduled to appear before Superior Judge Edmund Mogan tomorrow to resume the civil lawsuit which arose out of a dispute over fees between her and the attorney who represented her before federal authorities in the income tax case. Hartley Russell, tax attorney, said that he was reasonably entitled to $7,000 for representing her and that she has paid only $1,000. Suit against her was brought in the name of V. Snediker, holding an assignment of the claim. She was sued as Inez L. Burns, her legal name. She is the wife of Joseph F. Burns, former assemblyman. Admitting existence of the federal claim, Mrs. Brown claimed Mr. Russell terminated their relationship by agreement. She asks return of $2,000 which she said she paid him." (San Francisco *News,* May 10, 1938.)

"News that Dr. Romano Nicholas Trotsky (Dr. Romano Lukian) was being held for wife desertion in San Angelo, Texas, today recalled a series of hoaxes in the Bay area. Thomas Hunter (Special Agent) and Dr. Charles B. Pinkham of the State Board of Medical Examiners said Doctor Trotsky was refused a medical license here, represented himself as a bachelor nephew of exiled Leon Trotsky and told a thrilling story of his 'escape' from Russia. His police record, according to Mr. Hunter, includes convictions for auto theft, forgery, swindling, violation of the state medical laws, and several suspended sentences for abortions" (San Francisco *News,* May 2, 1938). Newspaper reports relate that Trotsky was brought to Del Rio, Texas, for investigation by the United States Immigration and Naturalization Service in reference to his entrance into the United States. (Previous entry, April, 1937.)

(Continued in Front Advertising Section, Page 18)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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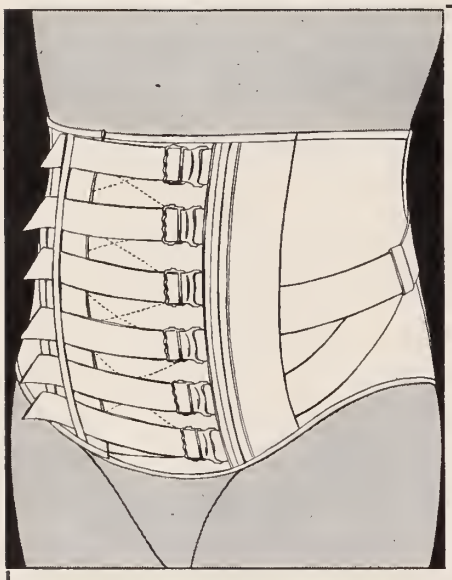
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Concerning Cancer.—Cancer has risen in the last twenty-five years from sixth to second place in the rank of killers of mankind—yet today because of scientific progress there is more reason for hope about this disease than ever before, according to the American Society for the Control of Cancer.

This sharp increase in the rate of death from cancer may well be more statistical than real, according to authorities. They point out that two factors contribute largely to it:

1. The upward trend in age levels of our population. As more people live longer, reaching the so-called cancer belt, over forty, there are naturally more deaths from this malignant disease. Improved techniques for dealing with tuberculosis, malaria, scarlet fever, etc., leave more people for the degenerative diseases of old age, among them cancer.

2. Improved diagnostic techniques: when a person dies of cancer now it is recognized as such. Lack of skill in diagnosis usually explains the legends that certain primitive peoples, among them the American Indians, never had cancer.

Cancer of the breast in its early stages is one of the most curable of serious diseases. If taken when still local, it may be cured in 75 per cent of the cases, according to the American Society for the Control of Cancer.

What causes cancer—sudden, wild growth of certain cells—along one of the milk ducts is not entirely understood. It is probably due to chronic irritation of some sort and to hereditary susceptibility.

Good rules for guarding against cancer of the breast:

1. Go to a physician as soon as one notices a lump in the breast. Only 10 or 15 per cent of these will be cancer, but they should be promptly investigated. It is dangerous "to wait and see what will happen" to such a lump. If because of delay cancer cells have metastasized or spread to other parts of the body, the odds are five to one *against* a patient instead of, as in early cancer, three to one in her favor.

2. Be sure to have a complete physical examination once a year by a competent physician.

Despite the widespread popular belief, a blow on the breast will not cause cancer, declare the experts associated with the American Society for the Control of Cancer.—"Bulletin of the American Society for the Control of Cancer."

Expansion of the Sickness Insurance in Germany.—Provisional 1937 statistics for the aggregate of official Sick Insurance organizations indicate an excess of income over expenditure. The number of clubs declined somewhat during the year; there are now 4,598 such units. Total membership increased from 19,400,000 to 22,900,000. Official circles are now attempting to place all Sick Insurance more within the scope of national-political economics. For example, insurance club members with large families are to be eligible for more substantial benefits without any additional contributions being required of them.

Just released by the National Bureau of Statistics are some figures on Sickness Insurance disbursements during the year 1935. These statistics, shown in the accompanying table, represent in round numbers the amounts paid out for various purposes by the clubs under direct governmental control by the Miners' Clubs and by the Supplementary Clubs.

Thus exclusive of the cash benefits paid to members and the costs of administration around 998,000,000 marks was expended by the Sickness Insurance in 1935. It is estimated that the expenditures during 1936 were about 4 per cent greater than in 1935.

Sickness Insurance Disbursements During 1935

Medical and dental treatment	461,000,000 marks
Therapeutic substances and appliances, hospital care and convalescent care	324,000,000 marks
Care of members' dependents	97,000,000 marks
Care during confinement	110,000,000 marks
Prophylaxis and hygiene	5,500,000 marks



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Insulin-Hypoglycemia Treatment of Schizophrenia. Cameron discusses certain of the reactions which occurred during the insulin treatment of schizophrenia in twenty patients. Fifteen of the group are considered "old" cases, since the schizophrenic symptoms have persisted for more than a year. The relation between the period of interruption and the subsequent behavior constitutes one of the major guiding principles of the insulin treatment. Not only the behavior prior to termination, but also the depth of the reaction and perhaps the speed of termination have an influence on the succeeding behavior. The relationship between the post-treatment behavior and these three factors varies considerably from patient to patient, but is relatively constant in a given case over periods to be reckoned in terms of weeks. Improvement is most frequently associated with interruption of treatment during any one of four fairly distinct phases. The first phase consists in a period of wakefulness, accessibility and relative clarity, which, with moderate doses, may appear between one and two hours after injection. The second phase consists in the biphasic (clonic) jerking. The third phase consists in the period during which the patient is beginning to enter coma. The fourth phase consists in deep coma in which the patient shows no response to auditory stimulation and in which the corneal reflex is gone. The phases in which the authors have empirically found it most expedient to terminate the reaction are the first and the fourth: the periods of most relative clarity and of deep coma. Importance attaches to the nature of improvement and to the nature of relapse. A further aspect of improvement that is of considerable interest is the concomitant increase of erotic activity. The concept of the "reversal of the psychosis" is considered erroneous. The phenomena so described are considered as arising from an interplay between the growing or lessening stability of the organism and varying degrees of intervals of tissue oxygenization. The author has not witnessed in his cases the high remission rates reported from European centers. Of his twenty subjects, three are able to be at home on a fairly stable basis, and one patient, who had shown previous good remissions sometimes in apparent response to thyroid, sometimes spontaneously, also showed a good remission after a few weeks of insulin treatment and could be discharged if suitable placement was available. Three others have been home on visits, but are still on treatment. A further six are still on treatment, and in the remaining seven treatment has been stopped because of physical conditions or because the response was not sufficiently favorable to warrant further treatment.—*Journal of Nervous and Mental Disease.*

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CHLORINE	38.3 parts per million
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NITRATE	0 parts per million
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Periodic Medical Examination of Automobile Drivers.—At the January 25 meeting of the Académie de médecine a paper was read by Professor Parisot and Dr. G. Richard of Nancy on medical examination of automobile drivers. In 1937 there were 1,700,000 passenger automobiles and 155,000 trucks here as compared with 100,000 twenty years ago. During the last few years there have been between 3,000 and 4,000 deaths and from 50,000 to 70,000 injured annually in France, despite numerous precautions taken to prevent automobile accidents. At the sixteenth medico-legal congress, held in 1931, it was shown that more deaths were due to automobile injuries than to typhoid and diphtheria combined. The human factor is responsible for accidents in from 36 to 80 per cent, according to various statistics cited. Medical examination of chauffeurs has been advocated by the Académie de médecine since 1930. Such tests are already obligatory for drivers of passenger cars and trucks in seventeen European countries. In four others (France, Austria, Belgium, and Switzerland), such an examination is required only of truck drivers. Gratifying results have been noted in Paris since 1928, when medical examination was first required, of all candidates for positions as chauffeurs and mechanics of motor busses and subway trains in Paris. In 1923 there was one accident for each 105,000 passengers and in 1936 only one to 212,300 passengers.

The authorities here have always opposed extension of obligatory medical examination to all chauffeurs, citing England as an example of a country in which there are comparatively few accidents although medical examination is not compulsory. The authors showed the fallacy of this argument by citing statistics of automobile accidents in both England and the United States. There were 204,710 accidents in England in 1933, and as the result of more strict control of the granting of driving licenses this number dropped to 195,892 in 1935. There were 7,343 deaths in 1934 as compared to 6,502 in 1935, and the number of injured dropped from 231,603 in 1934 to 221,726 in 1935. A system of periodic examinations for all taxicab drivers who were above a certain age or showed physical defects was instituted in England in 1936. Every chauffeur above the age of fifty is obliged to submit to a medical examination every six years up to the age of sixty-five, every five years between the ages of sixty-five and seventy-three, and every year thereafter.

A number of examples were mentioned by the authors of fatal accidents due to cardiovascular disturbances in chauffeurs. The authors advocated the passage of a law in France making periodic medical examinations obligatory. This should be carried out according to the following schedule: Every six years for all chauffeurs from eighteen to forty-five years of age, every five years between the ages of forty-five and fifty-five, every three years between the ages of fifty-five and sixty, every two years between the ages of sixty and sixty-five and every year above the age of sixty-five.

Following the reading of this paper, a committee of six fellows of the Académie de médecine was appointed to draw up a law covering these recommendations. (Paris correspondent, Journal of the American Medical Association.)

Low Fat Tolerance in Hot Weather.—During the hot weather, when fat tolerance is lowest, many physicians have found it a successful practice to transfer cod liver oil patients to Mead's Oleum Percomorphum.

Due to its negligible oil content and its small dosage, this product does not upset the digestion, so that even the most squeamish patient can "stomach" it without protest.

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Treatment of Acute Alcoholism.—Piker maintains that two cardinal points of attack exist in the treatment of acute alcoholism. They are the stopping of further absorption of alcohol into the blood stream (which involves cessation of drinking and removal of any alcohol remaining in the stomach) and the increasing of circulatory and respiratory efficiency so as to hasten the elimination of alcohol and other existing toxic substances from the tissues, which is best accomplished by caffein. Lavage and caffein, then, provide the core of the therapy of acute alcoholism. Oral magnesium sulfate, alkalis, and fluids are indicated in all cases. For the various more difficult complications, intravenous hypertonic sucrose or dextrose, spinal fluid drainage, paraldehyd, carbon dioxid and oxygen inhalation, heat and apomorphin may be utilized according to the needs in the specific case, but with the use of apomorphin the cardiac condition should be known, as death from heart failure may be the result. Therapy in acute alcoholism, as in all other pathologic conditions, should seek to be rational whenever possible and should not be distorted by the physician's desire to appear spectacular or to relieve himself as quickly as possible of a cumbersome patient.—*Ohio State Medical Journal.*

Marihuana.—Marihuana is the Mexican name for a plant which has recently caused quite a bit of commotion in the United States and also quite a lot of legislation. Nearly every state has passed laws in regard to its distribution, and the Federal Government has considered the situation serious enough to justify a bill to control the growth of the plant and to give marihuana a separate listing among narcotic drugs.

While its use is a new and alarming thing in this country, preparations made from the plant have been either smoked, chewed, or drunk for many centuries in the Old World.

The Assyrians, Egyptians, Greeks, and Romans were familiar with its use and effects, and it was cultivated by the Chinese centuries before the Christian era. It made its first appearance in the western hemisphere in Mexico and from there spread to the United States. Its distribution is now so widespread that, in addition to its cultivation, it may be found growing wild along the roadsides and upon vacant lots in many states, particularly in the West.

The proper name for marihuana is cannabis sativa and cannabis indica; Indian hemp and hashish are synonymous. The plant's commercial value, aside from its narcotic uses, accounts largely for its cultivation throughout the centuries. Twine, rope, bags, and even clothing have been made from its fiber, and it has been found that a rapidly drying oil, useful in paints and varnishes, may be extracted from its seeds.

Indulgence in marihuana in this country is usually by cigarette, and its effects vary with the amount of smoke inhaled, the potency of the leaves (this varies in different plants), and with individual susceptibility.

Usually the first noticeable change in the smoker is the failure to control thoughts and actions, and there is a feeling of increased power and energy and a sense of general well-being. Perception in the matter of time and space is disturbed and illusions occur. Stimulation of the imagination may continue to delirium and a reckless abandon may extend to violence.

In habitual users of the drug the slightest provocation may evoke a violent state and many such subjects are incurable and may end in dementia.

Multiplying Safety.—When your speedometer goes to 50, think of 55 feet. That is how far the car will travel after you decide to stop, before your foot can touch the brake pedal. When the speedometer says 40, think of 44 feet; if 30, 33 feet, and so on. Experts call this the "reaction distance."

To find out how much you need to stop safely at 40 or 50 miles an hour, multiply the "reaction distance" by three. At 50 miles an hour, you would multiply 55 by three, and you know that a distance of 165 feet would be necessary to stop the car.—Barney Oldfield, in *Chicago Journal of Commerce.*



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Protection of Eyesight.—Remarkable advances, during the past thirty years, in the program for the protection of eyesight in America—pointing to the possible elimination of the principal diseases causing blindness, the reduction of eye injuries to a minimum, and removal of the chief reasons for eyestrain—are indicated in the recent annual report of the National Society for the Prevention of Blindness, 50 West Fiftieth Street, New York City.

"Efforts to prevent loss of sight from disease were given added impetus in 1937 by the unusual progress of the campaign to stamp out syphilis, an important cause of blindness," the report says. "Laws requiring premarital medical examinations and a blood test for every expectant mother, when adopted by all states, are expected to bring about a great decline in the amount of blindness from syphilis—just as legislation requiring prophylactic drops in the eyes of infants at birth has eliminated ophthalmia neonatorum as a major cause of blindness among children.

"The ten pioneers who established the New York State Committee for Prevention of Blindness, in 1908, were interested mainly in fighting ophthalmia neonatorum, commonly known as babies' sore eyes," the report explains. "From this beginning grew the National Society for the Prevention of Blindness, with its 18,000 members and donors, whose services now extend from the protection of the eyes of the newborn to the preservation of sight in old age.

"Three decades have passed since the small group of public-spirited men and women who organized the movement for prevention of blindness turned their eyes prophetically toward the future. The work they started is, in a most literal sense, enabling thousands of men, women, and children, who might have been blind, to see."

Definite benefits are resulting from the annual campaign for a "safe and sane" celebration of Independence Day, according to the report, crediting state laws which forbid the sale of fireworks except for use by pyrotechnic experts. The Society calls attention, however, to the fact that hundreds of children and adults continue to suffer eye injuries—and that some are blinded—through accidents from fireworks every Fourth of July. "Other sources of accidents to the eyes of children are air-rifles, air guns, and BB guns," the report comments. "New York City and Baltimore during the past year enacted ordinances prohibiting the sale and use of such weapons or toys, and it is expected that these laws will help to reduce accidents to the eyes."

The report discloses that the number of "sight-saving classes" for the education of children with seriously defective vision has increased from the two established in 1913—one in Boston and one in Cleveland—to 558 maintained at the present time in 182 cities throughout the United States; and that forty-four were established in 1937. The children in these classes are provided with books in large type, movable desks, and ideal lighting conditions; and their teachers are specially trained.

The Society's income amounted to $120,000. Since its expenditures amounted to $154,000, it was necessary to use $34,000 from the Reserve Fund. Approximately 500,000 copies of various publications were distributed among doctors, nurses, teachers, social workers, and the general public. A motion-picture film, entitled "Preventing Blindness and Saving Sight," was exhibited to 1,100 audiences with a total attendance of 150,000.

Public Relief.—Costs of public relief in March continued the rise recorded for the five preceding months, according to figures issued today by the Social Security Board. Total federal, state, and local costs incurred for aid to the needy in March, including earnings under the Works Program, amounted to $234,800,000, an increase of approximately $18,000,000, or about 8 per cent, over the total for February.

Figures reported by the Board are compiled regularly in collaboration with other federal agencies and state and local authorities. The March figure includes amounts for the various programs as follows: Public assistance to the needy aged, to the needy blind, and to dependent children

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from federal, state and local funds under the Social Security Act, and other public assistance of these special types, $41,244,000; earnings under the Works Program, including the Works Progress Administration and other federal agencies through which wages were paid to persons certified as in need of relief, $124,528,000; Civilian Conservation Corps, $18,558,000; subsistence grants under the Farm Security Administration, $2,583,000; general relief in cash and in kind, by states and localities, $47,887,000. These sums represent substantially all public aid received by the needy, with the exception of aid to transients. Administrative costs are not included.

On the basis of reports received by the Board it was estimated, after allowance for duplications, that in March approximately 6.3 million different households, probably comprising about 19.9 million persons, received public aid of one or more of the types mentioned above. As compared with February, there was an increase of 5 per cent in the number of different households in receipt of public aid.—*Bulletin of the Social Security Board (Press Service).*

Vitamin D and Myopia.—During the last six years there have been forty-eight myopic patients whom Laval has considered young (from 5 to 17 years of age) enough for trial treatment with vitamin D and milk. These patients have taken vitamin D and milk continuously and have been seen at intervals of nine months for from three to six years. In every one of these patients there has been an increase in the amount of the myopia. In some the increase has been only one diopter; in others it has been as much as 2.5 diopters, but not one patient has had a decrease in the amount of the myopia or even an arrest of the progress. All the dietetic and hygienic measures instituted were of no avail in arresting the progress of the myopia. Accordingly, the author disagrees with those who say that treatment with vitamin D and calcium helps patients who have myopia by reducing the amount of the myopia, keeping it stationary or preventing as rapid an increase as is usually found in patients who have not used this form of therapy.—*Archives of Ophthalmology.*

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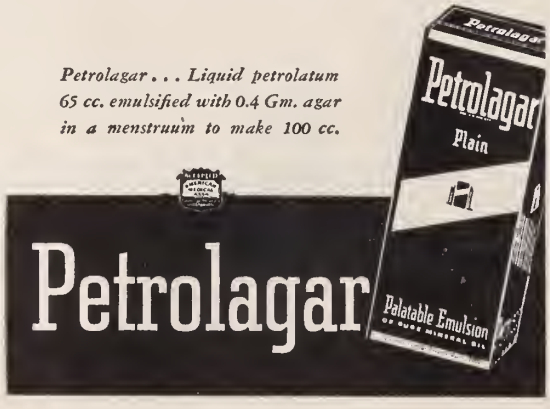


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"State Medicine" in Rural Areas Cited in Report.—State medicine now exists, in fact, in many rural communities in the United States, and the organized medical profession in those communities likes it.

This situation, which may surprise many, in view of the opposition by organized medicine to anything resembling state medicine, appeared in the report of Dr. R. C. Williams, Medical Director of the Farm Security Administration, to the Conference of State and Provincial Health Authorities of North America at the United States Public Health Service here.

Not Mentioned by Name.—Doctor Williams did not mention state medicine in his report, which is the first public announcement of how the Farm Security Administration is helping farmers secure and pay for medical care for themselves and their families. The system is state medicine in the sense that the money for medical care now comes from the Federal Government. It is not state medicine in that the money is a loan to the farmer, which is being repaid, and in that physicians are not being paid regular salaries by the Government, except in a very few special instances.

Typical of the general program, although details vary in different states and counties, is the situation in Arkansas. There the arrangement has been worked out by agreement between the Farm Security Administration and the Arkansas State Medical Society.

Bills Are Approved.—The Farm Security Administration arranges for each of its farmer clients to pay each month into a medical coöperative fund a certain sum for medical care for himself and family. The amount is fixed by the Administration on the basis of the farmer's estimated annual income. The farmer calls the doctor of his own choice when he or his family needs medical attention. The doctor submits his bill for review by an officer of the medical society who decides on its fairness and authorizes payment on a percentage basis from funds set apart as the coöperative funds for medical services.—*Science Service.*

UMBILICAL AND INCISIONAL HERNIA SUPPORTS

The use of incisional and umbilical hernia supports preliminary to operation is stated by a writer* in the current medical literature as follows:—"... in cases in which the hernia has protruded from the abdomen for some time, if the abdomen can be so compressed by artificial means that the hernia is replaced and the patient can readjust himself to the normal environment of the intestine in the abdomen, there is less likelihood of postoperative distension and vomiting."



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*BANCROFT. Pennsylvania Medical Journal..November 1936

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Modern Weapons Against Cancer.—It is a far cry from the slingshot, the crossbow, the spear, the hideous masquerades, and invocations to spirits of primitive man to the modern machine gun, high explosives, aeroplanes, and poison gas as weapons for both offensive and defensive warfare.

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Weapons with which the inroads of every disease known to affect humanity have been fought have changed greatly during the ages, and those employed against cancer have shared in this change. Cancer is one of the oldest known diseases, and earliest historical writings are replete with references to weapons used against it. While surgery and heat in some form have been used to treat cancer through the historical era, other methods of little or no value were also employed. As the nature of cancer was but imperfectly understood by the ancients they employed all known artifices in its treatment. Many of their beliefs and practices have persisted to the present time, some modified, others much as they were known at that day.

To mention but a few of these ancient practices, Galen, who lived from 131 to 203 A. D., prescribed very mellow figs, human feces, oils, and pastes for treatment. Guy de Chaullac, whose life dated from 1300 to 1368 A. D., recommended the eating of fish and crabs from rocky streams, the wearing of emeralds and sapphires as preventives, and, for treatment, the daily applications of fresh hen's flesh to the area of cancerous growth held in place by a scarlet cloth.

In the war on cancer the attacking army is composed of but two individuals—the patient and the physician. While these two must act in concert to bring about the desired

(Continued on Next Page)



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(Continued from Preceding Page)

victory, each will use weapons peculiarly adapted to his position on the battle front.

The patient's first act in this battle for life is to rid himself of certain handicaps that interfere with a successful attack. The greatest of these handicaps is the fear that hampers action for self-protection. Cancer is feared because its nature is not understood. It is a mysterious condition to the average person, whose very name strikes terror to the minds of many people. By becoming informed as to the nature and cause of cancer this unreasoning fear can be turned into a healthy protective caution that will become an asset to the patient rather than an ally to the disease.

Among the strongest weapons at the command of the patient are information and knowledge as to the nature and cause of cancer. He must recognize that his cancer is a part of his own tissues, that it is neither contagious nor infectious, nor is there any social stigma attached to the cancer patient.

Before he becomes a cancer patient, the individual should use his most effective weapon, the periodic physical examination, in order to detect the beginnings of the disease. Not only cancer, but many other diseases thus can be detected early in their course and may be prevented by the discovery and correction of minor abnormalities. For both patient and physician this procedure becomes the first line of defense in the warfare on cancer.

If for any reason a person cannot employ the periodic examination as a defensive weapon, he can equip himself with another defense second only in importance to the former. He can know the early signs of cancer, and go at once to his physician when suspicious symptoms develop. The early signs, the "danger signals," are:

1. A painless lump that persists, especially in a woman's breast.
2. A sore that does not heal, particularly about the face, mouth, or lips.
3. An unnatural blood-stained discharge from a natural body opening.
4. Persistent indigestion, often with loss of weight.
5. Sudden changes in size or color of warts and moles.

The cancer patient must use the weapon of courage and be willing to face his situation frankly. He must overcome the fears with which the average patient's mind is so often beset and realize that he cannot run away from his cancer nor influence it by refusing to admit its presence. Cancer cannot be prevented or cured by thinking about it.

An important weapon at the patient's disposal is his confidence in the ability of his physician to see him safely through his treatment. The patient must coöperate with the physician in whatever procedures are necessary in treatment and follow-up. The coöperation between physician and patient has only begun when the first treatment has been given. At least a five-year period must pass before any cancer patient can be classed as cured, and recurrences are found often enough after this period to warrant regular observations during the remainder of the patient's life.

Another excellent weapon against cancer is the patient's willingness to be known as a cured case. This attitude will engender more optimism in the public mind than will almost any other procedure. It will help to dissipate the fallacy that cancer always kills, no matter what treatment is given. When it is realized that there is now an authentic record of more than 29,000 cured cancer patients in the files of the American College of Surgeons, the importance of an optimistic attitude on the patient's part cannot be overemphasized.

The cancer patient plays directly into the hands of the enemy when he resorts to home treatment, listens to the advice of and uses the remedies prescribed by the local druggist, or goes to quacks who advertise or guarantee a cure. Any person who advertises or guarantees a cure, or who demands payment in advance of treatment, is an irresponsible quack and is to be shunned as one would shun a mad dog. No ethical, reputable physician will do any of these things.

If the pastes used by quacks did cure cancer, its treatment by surgery, x-ray, or radium is more precise and effective and much less painful and disfiguring to the patient.

One of the patient's best weapons in his war on cancer is to refuse to listen to the claims of the advertising quack, or the sympathetic advice of friends and relatives extolling the virtues of home remedies, going instead to a reputable physician for such treatment as he deems necessary.

When the public and the medical profession fully realize that cancer is not a single disease, as is tuberculosis or typhoid fever, and that different methods must be used in the diagnosis and treatment of the various types met with, distinct progress will have been made in its control.

The physician has at his command effective weapons with which to fight cancer. One of the most useful is the careful periodic examination of the apparently well person.

(Continued on Page 48)



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Consultant, General Surgery

EMILE HOLMAN, M.D.
(Stanford Hospital), Consultant, Thoracic Surgery

(Continued from Page 46)

who wishes to know that he is free from this disease. The physician, more than the patient, must know the significance of abnormal conditions that may be either the forerunner of cancer or cancer in its early stages. He must appreciate that cancer detected early is curable in the large majority of cases and take definite action whenever indicated.

The physician who takes lightly an apparently healthy individual's request for an examination to detect the presence or absence of cancer plays directly into the hands of the enemy. All too often the beginnings of cancer are so insidious that the disease is firmly established before giving any visible evidence of its presence. This is the reason why it is necessary to look for it in the apparently healthy person where, if present, it can be found and destroyed without serious consequences to the patient. No physician worthy of the name should ever refuse a reasonable request for an examination to detect the presence of cancer any more than he would refuse to make an examination for any other purpose.

Another modern weapon used by the physician in this warfare against cancer is the microscope. In the hands of a competent physician this weapon searches out the hidden nests of cancer cells in a tissue subjected to examination by it, and often finds these lawless intruders in tissues where their presence was not suspected.

A companion weapon to the microscope is the x-ray, most useful in detecting cancer in internal organs and bones. Cancer in the stomach, intestines, lungs, kidneys, brain, and other internal structures, as well as the bones, is more easily detected by the x-ray than by any other means. Its value as a diagnostic weapon is also being established in regard to other organs and tissues.

Few cancerous growths are so situated that they cannot be removed by surgery or destroyed by radiation, provided they are discovered early in their growth. Surgery with its modifications as cauterization or burning, has been employed as a curative weapon throughout the historical era, and probably long before. Radium and x-rays are the only other curative weapons used against this disease. Their value has been fully established, but they are most effective only when used by physicians with adequate training and experience in the physical problems surrounding their action on living tissue. The use of the x-ray for treatment is more likely to be confined to those with special training in this field because of the expense involved in the purchase and installation of this equipment. On the other hand, radium in almost any desired quantity and form can be rented at no expense to the physician. The use of radium under these conditions is no more a measure of ability to use it than the possession of a kit of surgical instruments would indicate ability as a surgeon.

Occasionally some physician will resort to a weapon now fully discredited and considered almost as much of an outlaw as is cancer itself; the "watchful waiting" weapon, whereby the physician advises the patient with suspicious symptoms to watch them for a few weeks or months to see what additional signs will develop to help in the diagnosis of the case. This weapon is as out of date as is the blunderbuss or bow and arrow as weapons of modern warfare. There is no excuse for a physician to wait longer than the few days needed to establish the diagnosis before beginning the indicated treatment. Each day's delay lessens the patient's chance for a cure.

An important weapon at the disposal of the physician is the knowledge that enables him to be the adviser to his patients about the hopeful aspect of the cancer problem. Knowing that the number of cancer deaths can be reduced by half if existing knowledge about the control of this disease is fully utilized, the physician must maintain an optimistic attitude toward the problem if he is going to help his patient lose his fear and stop his fallacious thinking about his condition. So long as the physician feels that he is fighting a losing battle, just so long will the patient reflect this attitude.—Frank L. Rector, M. D., Field Representative, American Society for the Control of Cancer.

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

IV. SEALING THE TIN CONTAINER

BRIEFLY, the method of food preservation commonly known as "canning" involves subjecting food in a permanently sealed container to a heat process. The heat process destroys spoilage organisms present on the raw food material; the seal on the container prevents reinfection of the food by such organisms. It is, therefore, obvious that the sealing operation—"closing" or "double-seaming" as it is known in the industry—is one of the most important in the canning procedure.

The manufacture of tinplate and "sanitary" cans is described elsewhere (1).

The open cans are received at the cannery in paper cartons or in washed paper-lined box cars, together with the covers which are contained in fiber shipping tubes. Figure 1 shows a can and end ready for use.

In modern canning practice, the cans are first conveyed by automatic runways to can washers, and thence to the filling tables or fillers where the correct amount of properly prepared raw food is put into the cans. The covers or "ends" are placed in the automatic sealing or "closing" machine to which the open can containing the food is mechanically conveyed. In this machine the ends are "double-seamed" onto the can. This operation is portrayed by the accompanying cross-sectional pictures.

In Figure 2 is shown the relation of can to cover before the sealing operation is started; note the relative position of the "curl" on the cover and the "flange" on the can. In this curl, the can manufacturer has placed a gasket or "compound," usually containing rubber. Figure 3 is a series of photographs illustrating the sealing operation in which the curl and flange are first rolled into position and then the layers of metal flattened together to form the final "double-seam" in Figure 4. The rubber compound originally present on the cover supplies the binding material between the layers of metal necessary to insure a permanent or hermetic seal on the container. Figure 5 illustrates in cross-section a closed sanitary can as it comes to the consumer.

In the past twenty-five years great progress has been made in the development of tinplate, compounds and automatic sealing machines. Collectively, these developments enable present-day canners to impose a permanent seal on the cans containing their products more easily and rapidly than ever before in the history of canning.

(1) The Story of the Tin Can, American Can Company, New York, 1935



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SUPPLEMENT TO

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CALIFORNIA MEDICAL ASSOCIATION

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FOREWORD

EDITOR'S NOTE.—*For many years, the California Medical Association has printed annually a Membership Directory, some issues having more than two hundred pages. In recent years, the Board of Medical Examiners of the State of California, with headquarters at 417 State Office Building, Sacramento, has also printed a directory, containing the name, date of birth, years of licensures in different states, and the office address of every physician and surgeon licensed under its jurisdiction. The State Board Directory has also contained much other information concerning the Medical Practice Act, and narcotic and other laws related to healing-art practice in California. A copy of each year's directory is sent to every physician and surgeon who has a license to practice in California.*

Directories of the California Medical Association brought off the press in the past have also presented historical and other information of similar nature.

In order to avoid duplication of printing and other costs, the California Medical Association in the last few years has printed a membership roster giving the names of members and the city or location in which they practice, with key numbers to indicate county medical society membership. This information, when used in connection with that given in the directory of the State Board of Medical Examiners, should answer all ordinary needs.

For additional information, inquiry should be made of the secretaries of the California Medical Association or the Board of Medical Examiners of the State of California.

For reference convenience, CALIFORNIA AND WESTERN MEDICINE *is printing this Membership Roster, containing the names of all members through date of December 31, 1937, as a supplement to its February issue. For possible future use, members are advised to place this Membership Roster Supplement in their library files.*

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Secretary, Gertrude Moore, 2404 Broadway, Oakland.
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Butte County Medical Society
President, Raymond Kilduff, 322½ Meyers Street, Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Selby H. Marks, Grabstein Bldg., Pittsburg.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
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Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
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Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

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Secretary, William A. Clarke, Holtville.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, Harry W. Lange, Hopkins Bldg., Bakersfield.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8 p.m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, George H. Kress, 945 Roosevelt Bldg., 727 W. 7th St., Los Angeles.
Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays. 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, W. Scott Polland, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Thomas P. Hill, Lakeport.
Secretary, Charles A. Craig, Lakeport.
Meeting, *On Call.*

Merced County Medical Society
President, E. M. Soderstrom, Merced.
Secretary, Fred O. Lien, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

*Deceased

Monterey County Medical Society
President, Curtis B. Gorham, 215 Franklin Street, Monterey.
Secretary, Harold R. Lusignan, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Walter Rapaport, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, G. Wendell Olson, 211 No. Pomona St., Fullerton.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. Ettrick Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, D. D. Roos, Corona.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Dave Dozier, California State Life Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, *L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Delbert B. Williams, 401 North Eighth Street, Colton.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, Bryant R. Simpson, 1205 Medico-Dental Building, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William C. Voorsanger, 490 Post St., San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, A. C. Boehmer, Box 306, Lodi.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Frederick R. Mugler, 1170 Marsh Street, San Luis Obispo.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

San Mateo County Medical Society
President, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, E. J. Lamb, 1515 State Street, Santa Barbara.
Secretary, J. Jerome Rupp, 16 E. Junipero Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, E. O. G. Schmitt, 608 Medico Dental Bldg., San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, Dean S. Woodard, Stoesser Bldg., Watsonville.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Mathew D. Pratt, Fall River Mills.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, E. F. Carlson, Fort Jones.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Second Sunday.*

Solano County Medical Society
President, Ream S. Leachman, 727 Sonoma St., Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Alfred A. Thurlow, 505 B St., Santa Rosa.
Secretary, C. M. Carlson, 534 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Joseph L. Azevedo, Jr., 1024 "J" Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, E. R. Zumwalt, Tulare.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, Grundy C. Coffey, Bank of America Building, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Charles S. Roller, Woodland Clinic, Woodland.
Secretary, W. J. Blevins, Jr., Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society
President, Neal M. Loomis, Yuba City.
Secretary, Fred W. Didier, Wheatland.
Meeting, *Second Tuesday.*

OFFICERS OF SCIENTIFIC SECTIONS
CALIFORNIA MEDICAL ASSOCIATION

Anesthesiology
Chairman, William LeRoy Garth, Medico-Dental Bldg., 233 A Street, San Diego.
Secretary, John G. Dunlop, 111 No. Normandie Avenue, Los Angeles.

Dermatology and Syphilology
Chairman, Stanley O. Chambers, 826 Roosevelt Building, 727 West Seventh Street, Los Angeles.
Vice-Chairman, Arne E. Ingels, 490 Post Street, San Francisco.
Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

Eye, Ear, Nose and Throat
Chairman, Frank Baxter, 1624 Franklin Street, Oakland.
Vice-Chairman, Dewey R. Powell, Medico-Dental Building, Stockton.
Secretary, Clifford B. Walker, 427 West Fifth Street, Los Angeles.

General Medicine
Chairman, Edwin L. Bruck, 384 Post Street, San Francisco.
Secretary, Howard F. West, 602 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

General Surgery
Chairman, Harlan Shoemaker, 1014 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Nelson J. Howard, 2814 Lyon Street, San Francisco.
Assistant Secretary, Ray B. McCarty, 3616 Main Street, Riverside

Industrial Medicine and Surgery
Chairman, Frederic C. Bost, 384 Post Street, San Francisco.
Vice-Chairman, Harvey G. McNeil, 523 West Sixth Street, Los Angeles.
Secretary, George H. Sanderson, 242 North Sutter Street, Stockton.

Neuropsychiatry
Chairman, Fred O. Butler, Sonoma State Hospital, Eldridge.
Secretary, John B. Doyle, 1930 Wilshire Boulevard, Los Angeles.

Obstetrics and Gynecology
Chairman, R. Glenn Craig, Medico-Dental Building, 490 Post Street, San Francisco.
Vice-Chairman, George W. Coon, 3770 Twelfth Street, Riverside.
Secretary, John N. Ewer, 411 Thirtieth Street, Oakland.

Pathology and Bacteriology
Chairman, Gertrude Moore, 2404 Broadway, Oakland.
Secretary, George D. Maner, 657 South Westlake Boulevard, Los Angeles.
Assistant Secretary, Paul H. Guttman, 1127 Eleventh Street, Sacramento.

Pediatrics
Chairman, E. E. Moody, 3780 Wilshire Boulevard, Los Angeles.
Secretary, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Assistant Secretary, W. W. Belford, 601 Medico-Dental Building, San Diego.

Radiology
Chairman, John D. Lawson, 1306 California State Life Building, Sacramento.
Secretary, Karl M. Bonoff, 1930 Wilshire Boulevard, Los Angeles.

Urology
Chairman, Lloyd E. Kindall, 400 Twenty-ninth Street, Oakland.
Secretary, Carl F. Rusche, 905 Taft Building, 1680 North Vine Street, Hollywood.

Delegates and Alternates to the American Medical Association

DELEGATES		ALTERNATES
C. A. Dukes, Oakland	(1937-1938)	Edward N. Ewer, Oakland
Edward M. Pallette, Los Angeles	(1937-1938)	W. H. Kiger, Los Angeles
Robert A. Peers, Colfax	(1937-1938)	F. F. Gundrum, Sacramento
William R. Molony, Sr., Los Angeles	(1937-1938)	John C. Ruddock, Los Angeles
Elbridge Best, San Francisco	(1938-1939)	Robert S. Stone, San Francisco
Lyell C. Kinney, San Diego	(1938-1939)	Bon. O. Adams, Riverside
J. P. Nuttall, Los Angeles	(1938-1939)	F. M. Pottenger, Los Angeles

Special Committees

Committee on Animal Experimentation
Philip Gilman, Chairman
Charles A. Dukes — Loren R. Chandler

Committee on Maternal Welfare
T. Henshaw Kelly.....San Francisco
Lyle G. McNeile.....Los Angeles
Ralph J. Thompson.....Los Angeles
T. Floyd Bell.....Oakland
Hans F. Schluter.....Sacramento

Committee on Golden Gate International Exposition
T. Henshaw Kelly, Chairman
Edward M. Pallette — F. C. Warnshuis
Charles A. Dukes — Hartley F. Peart

Committee on Syphilis
Howard Morrow, Chairman.....San Francisco
Charles W. Barnett.....San Francisco
William H. Goeckerman.....Los Angeles

Committee on a Qualifying Certificate (Basic Science) Law
George H. Kress, General Chairman
Los Angeles
Morton R. Gibbons, Chairman (for Bay Region), San Francisco
Edward M. Pallette, Chairman (for Southern California), Los Angeles
Junius B. Harris, Chairman (for Remainder of State), Sacramento

Woman's Auxiliary to the California Medical Association

State Auxiliary Officers
President, Mrs. Hobart Rogers, 1137 Mandana Boulevard, Oakland.
President-Elect, Mrs. Clifford A. Wright, 454 So. Irving Boulevard, Los Angeles.
First Vice-President, Mrs. Frederick Scatena, 1400 Forty-first Street, Sacramento.
Second Vice-President, Mrs. Elliott G. Colby, 2457 Willow Street, San Diego.
Recording Secretary, Mrs. Harry E. Henderson, 1600 Orange Road, Santa Barbara.
Corresponding Secretary, Mrs. Charles C. Hall, 207 Estates Drive, Piedmont.
Treasurer, Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael.

Officers of County Auxiliaries
Alameda County—President, Mrs. A. A. Alexander, 155 Woodland Way, Piedmont.
Butte County—Mrs. J. W. White, 314 W. Legion Avenue, Chico.
Fresno County—President, Mrs. A. E. Anderson, 1035 Cambridge Avenue, Fresno.
Kern County—President, Mrs. Jack Nicholson, 1821 Maple Street, Bakersfield.
Lassen-Plumas-Modoc County — President, Mrs. G. R. Fortson, 912 Lassen St., Susanville.
Los Angeles County—President, Mrs. Eliot Alden, 2008 North Serreno, Los Angeles.
Marin County—President, Mrs. Thomas Gocher, 201 Mt. View Avenue, San Rafael.
Monterey County—President, Mrs. Laurence M. Knox, Box 385, Carmel-by-the-Sea.
Orange County—President, Mrs. G. Wendell Olson, 219 Buena Vista Drive, Fullerton.
Riverside County — President, Mrs. T. A. Card, 4592 Aurora Drive, Riverside.
Sacramento County—President, Mrs. W. J. Van Den Berg, 1316 Forty-sixth Street, Sacramento.
San Diego County—President, Mrs. Elliott G. Colby, 2457 Willow Street, San Diego.
San Francisco County—President, Mrs. Hans Barkan, 3653 Jackson Street, San Francisco.
San Joaquin County—President, Mrs. F. G. Maggs, 228 Fulton Street, Stockton.
San Luis Obispo County—President, Mrs. Jens Larson, 2000 Spring St., Paso Robles.
Santa Barbara County—President, Mrs. Clarence Roome, 2747 Questa Road, Santa Barbara.
Santa Clara County—President, Mrs. Henry Milo, Mountain View.
Santa Cruz County—Mrs. Alfred L. Phillips, 220 Escalona Drive, Santa Cruz.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California
San Francisco—State Office Building, McAllister and Larkin Streets. UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building, San Francisco.

California Northern District Medical Society
President—Percy B. Gallegos, 242 North Sutter Street, Stockton.
Secretary—Dave F. Dozier, 926 J Street, Sacramento.

Board of Medical Examiners of the State of California
San Francisco, Rm. 512, 450 McAllister St.
Los Angeles, 906 State Building.
Sacramento, 420 State Office Building.
President, William R. Molony, Sr., Los Angeles.
Secretary, C. B. Pinkham, Room 512, 450 McAllister Street, San Francisco.

Southern California Medical Association
President, Franklin R. Nuzum, Cottage Hospital, Santa Barbara.
Secretary, Robert W. Langley, 1002 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

The Public Health League of California
Executive Secretary, Ben H. Read. San Francisco office, 450 Sutter Street. Los Angeles office, Room 563, 1151 South Broadway.

Better Health Foundation
President, Reginald Knight Smith,* 490 Post Street, San Francisco.
Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco.
Treasurer, John Gallwey, 1195 Bush Street, San Francisco.
Secretary, Celestine J. Sullivan, 490 Post Street, San Francisco.

* Deceased.

MEMBERSHIP ROSTER : C. M. A.

COUNTY SOCIETIES INDICATED BY KEY NUMBERS

This roster gives the list of members for the year 1937. Deceased members are indicated by *.

KEY NUMBERS FOR COUNTY MEDICAL SOCIETIES

Key No.	Name
1.	Alameda County Medical Association.
2.	Butte County Medical Society.
3.	Contra Costa County Medical Society.
4.	Fresno County Medical Society.
5.	Humboldt County Medical Society.
6.	Imperial County Medical Society.
7.	Kern County Medical Society.
8.	Kings County Medical Society.
9.	Lassen-Plumas-Modoc County Medical Society.
10.	Los Angeles County Medical Association.
11.	Marin County Medical Society.
12.	Mendocino-Lake County Medical Society.
13.	Merced County Medical Society.
14.	Monterey County Medical Society.
15.	Napa County Medical Society.
16.	Orange County Medical Society.
17.	Placer County Medical Society.
18.	Riverside County Medical Society.
19.	Sacramento Society for Medical Improvement.
20.	San Benito County Medical Society.
21.	San Bernardino County Medical Society.
22.	San Diego County Medical Society.
23.	San Francisco County Medical Society.
24.	San Joaquin County Medical Society.
25.	San Luis Obispo County Medical Society.
26.	San Mateo County Medical Society.
27.	Santa Barbara County Medical Society.
28.	Santa Clara County Medical Society.
29.	Santa Cruz County Medical Society.
30.	Shasta County Medical Society.
31.	Siskiyou County Medical Society.
32.	Solano County Medical Society.
33.	Sonoma County Medical Society.
34.	Stanislaus County Medical Society.
35.	Tehama County Medical Society.
36.	Tulare County Medical Society.
37.	Ventura County Medical Society.
38.	Yolo-Colusa-Glenn County Medical Society.
39.	Yuba-Sutter County Medical Society.

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Associate members	24
Honorary members	24
Retired members	24
Deceased members (year 1937)	24

COUNTY SOCIETY MEMBERSHIP TOTALS

(Year 1937)

Alameda County	515
Butte County	23
Contra Costa County	50
Fresno County	117
Humboldt County	34
Imperial County	26
Kern County	50
Kings County	17
Lassen-Plumas-Modoc Counties	14
Los Angeles County	2360
Marin County	41
Mendocino-Lake Counties	23
Merced County	28
Monterey County	58
Napa County	36
Orange County	113
Placer-El Dorado-Nevada-Sierra-Counties	35
Riverside County	70
Sacramento County	148
San Benito County	6
San Bernardino County	146
San Diego County	275
San Francisco County	838
San Joaquin County	107
San Luis Obispo County	26
San Mateo County	63
Santa Barbara County	104
Santa Clara County	171
Santa Cruz County	32
Shasta County	17
Siskiyou County	15
Solano County	27
Sonoma County	49
Stanislaus County	42
Tehama County	9
Tulare County	35
Ventura County	33
Yolo-Colusa-Glenn Counties	28
Yuba-Sutter Counties	16
Active members	5797
Associate members	5
Retired members	63
Honorary members	2
Total all members	5867

Seventy-eight members died during the year 1937.

Note.—The California Medical Association by-laws provide for an annual directory. Because every member receives the annual directory of the Board of Medical Examiners of the State of California, and in order to avoid the great cost of duplication of such a directory, the California Medical Association Council has decided to print in the official journal a simple roster of members, giving for each member the city or place of residence, with a key number to indicate the county medical society in which membership is held.

For additional information concerning school of graduation, etc., the State Medical Board directory or the central office of the California Medical Association should be consulted.

Errors in the list here printed should be promptly reported to the central office of the California Medical Association, Four Fifty Sutter, San Francisco.

I. ACTIVE MEMBERS

—A—

Name	City	County Society No.
Abbott, C. L.,	*Oakland*	1
Abbott, C. N.,	*Ontario*	21
Abbott, F. F.,	*Ontario*	21
Abbott, G. K.,	*Ukiah*	12
Abbott, K. H.,	*Ontario*	21
Abbott, L. C.,	*San Francisco*	23
Abbott, U. S.,	*Richmond*	3
Abdun-Nur, A. S.,	*Los Angeles*	10
Abowitz, J.,	*Los Angeles*	10
Abraham, H.,	*Los Angeles*	10
Abraham, S. V.,	*Los Angeles*	10
Abraham, V. R.,	*Long Beach*	10
Abramson, M. J.,	*Los Angeles*	10
Abrons, Harry,	*Berkeley*	1
Achenbach, L. W.,	*Ventura*	37
Adams, B. A.,	*San Leandro*	1
Adams, B. O.,	*Riverside*	18
Adams, B. W.,	*Oakland*	1
Adams, E. L.,	*Galt*	19
Adams, J. H.,	*Oakland*	1
Adams, J. P.,	*Oakland*	1
Adams, L. E.,	*Escondido*	22
Adams, L. P.,	*Oakland*	1
Adams, W. C.,	*Oakland*	1
Adams, W. L., Jr.,	*Fresno*	4
Adelstein, L. J.,	*Los Angeles*	10
Agmar, A. R.,	*San Francisco*	23
Ahlem, J. E.,	*Livermore*	1
Ahrens, C. L.,	*Artesia*	10
Ainley, F. C.,	*Los Angeles*	10
Aird, J. L.,	*Manhattan Beach*	10
Aitken, H. C.,	*Berkeley*	1
Akesson, H. N.,	*Oakland*	1
Alanson, M. R.,	*San Francisco*	23
Albert, W.,	*Los Angeles*	10
Alberty, W. M.,	*East San Diego*	22
Albi, P.,	*San Francisco*	23
Alcazar, I.,	*Los Angeles*	10
Alcon, D. N.,	*Los Angeles*	10
Alden, B. F.,	*San Francisco*	23
Alden, E.,	*Los Angeles*	10
Alden, J.,	*San Francisco*	23
Alden, W. C.,	*Pasadena*	10
Alderson, H. E.,	*San Francisco*	23
Alderson, V. G.,	*Oakland*	1
Aldrich, W. S.,	*Los Angeles*	10
Alesen, L. A.,	*Los Angeles*	10
Alexander, A. A.,	*Oakland*	1
Alexander, E.,	*Oakdale*	34
*Alexander, E. W.,	*San Francisco*	23
Alexander, J. H.,	*Chico*	2
Algee, M. J.,	*Compton*	10
Allan, J. T. M.,	*Los Angeles*	10
Allen, A.,	*San Pedro*	10
Allen, A. B.,	*Los Angeles*	10
Allen, C. L.,	*Los Angeles*	10
Allen, C. S.,	*Los Angeles*	10
Allen, D. M.,	*Oakland*	1
Allen, E. G.,	*Patterson*	34
Allen, H. H.,	*Los Angeles*	10
Allen, H. W.,	*San Francisco*	23
Allen, J. R.,	*Los Angeles*	10
Allen, M. R.,	*Fairfax*	11
Allen, O. K.,	*San Francisco*	23
Allen, P. K.,	*San Diego*	22
Allen, R. E.,	*Reedley*	4
Allen, R. W.,	*Huntington Park*	10
Allen, W. B.,	*Oakland*	1
Aller, D. I.,	*Fresno*	4
Allington, H. V.,	*Oakland*	1
Allison, B. S.,	*Long Beach*	10
Allison, C. N.,	*San Diego*	22
Allum, A. W.,	*Glendale*	10
Almada, A. A.,	*Sacramento*	19
Alsberge, E. W.,	*Glendale*	10
Alsberge, R. C.,	*Santa Cruz*	29
Alter, S. M.,	*Los Angeles*	10
Althausen, T. L.,	*San Francisco*	23
*Alvarez, L. F.,	*Los Angeles*	10
Alward, H. C.,	*Los Angeles*	10
Amaral, E. A.,	*San Jose*	28
Ambrose, C. S.,	*Los Angeles*	10
Ammann, F. X., Jr.,	*Los Angeles*	10
Amthor, J. G.,	*El Monte*	10
Amyes, H. W.,	*Huntington Park*	10
Anders, J. C.,	*San Diego*	22
Anderson, A. C.,	*Petaluma*	33
Anderson, A. E.,	*Fresno*	4
Anderson, A. V.,	*Pasadena*	10
Anderson, B. N.,	*Burbank*	10
Anderson, C. M.,	*Hermosa Beach*	10
Anderson, C. R.,	*Los Angeles*	10
Anderson, C. W.,	*Bishop*	10
Anderson, E. A.,	*San Joaquin*	24
Anderson, E. DeM.,	*San Luis Obispo*	25
Anderson, E. F.,	*San Francisco*	22
Anderson, E. L.,	*Los Angeles*	10
Anderson, F. N.,	*Los Angeles*	10
Anderson, F. R.,	*Campbell*	28
Anderson, H., Jr.,	*Los Angeles*	10
Anderson, H. C.,	*Pomona*	10
Anderson, H. E.,	*Culver City*	10
Anderson, H. H.,	*Evanston, Ill.*	23
Anderson, J. F.,	*Los Angeles*	10
Anderson, J. G.,	*Petaluma*	33
Anderson, N. P.,	*Los Angeles*	10
Anderson, O.,	*Santa Monica*	10
Anderson, S. B.,	*Burbank*	10
Anderson, S. C.,	*Westwood*	10
Anderson, W. M.,	*Lompoc*	27
Anderson, W. N.,	*Los Angeles*	10
Anderton, H. S.,	*San Diego*	22
Andrews, A. V.,	*Livingston*	13

NAME	CITY	COUNTY SOCIETY NO.
Andrews, C. B.,	*Sonoma*	33
Andrews, H.,	*Los Angeles*	10
Andrews, H. F.,	*San Diego*	22
Andrews, H. J.,	*Hollywood*	10
Andrews, J. N.,	*Los Angeles*	10
Andrews, V. L.,	*Los Angeles*	10
Andrews, W. A.,	*Yucaipa*	21
Andrus, L. M.,	*King City*	14
Ankele, C. W.,	*Sacramento*	19
Annis, A. J.,	*Los Angeles*	10
Anthony, E. H.,	*Los Angeles*	10
Anton, F. L.,	*Los Angeles*	10
Appeldorn, H. H.,	*Oakland*	1
Apple, W. W.,	*El Centro*	6
Arbuthnot, R. E.,	*Glendale*	10
Archibald, H. C.,	*Salinas*	14
Arehart, A. A.,	*Monterey*	14
Arkush, A. S.,	*Santa Monica*	10
Armen, G. H.,	*Los Angeles*	10
Armitstead, R. B.,	*Ventura*	37
Armstrong, E. L.,	*Los Angeles*	10
Armstrong, M. I.,	*Berkeley*	1
Arndal, O.,	*Glendale*	10
Arnett, L. A.,	*Sierra Madre*	34
Arnold, F. L.,	*Long Beach*	10
Arnold, H. J.,	*San Jose*	28
Arnold, H. R.,	*San Francisco*	23
Arnold, W. F.,	*Long Beach*	10
Arnot, P. H.,	*San Francisco*	23
Arnov, B.,	*Los Angeles*	10
Arthurs, E.,	*San Francisco*	22
Ash, R. L.,	*San Francisco*	23
Ashcroft, F. E.,	*Chula Vista*	20
Ashley, K. C.,	*Huntington Park*	10
Ashley, N. N.,	*Oakland*	1
Ashley, R. E.,	*San Francisco*	23
Askey, E. V.,	*Los Angeles*	10
Askey, J. M.,	*Los Angeles*	10
Atkinson, C. E.,	*Banning*	18
Atkinson, D. W.,	*San Francisco*	23
Atkinson, R. C.,	*Colfax*	17
Atsatt, R. F.,	*Santa Barbara*	27
Atteberry, C. V.,	*Inglewood*	10
*Attwood, W. G.,	*Los Angeles*	10
Atwood, A. C.,	*Chowchilla*	13
Atwood, H. A.,	*Riverside*	18
Audrain, L. C.,	*Los Angeles*	10
Augspurger, E. D.,	*Lodi*	24
Austin, F. O.,	*San Diego*	22
Austin, L. C.,	*Los Angeles*	10
Austin, R. E.,	*Coronado*	22
Austin, T. C.,	*Pasadena*	10
Avery, J. W.,	*Hollywood*	10
Avery, R. W.,	*Los Angeles*	10
Avery, W. J.,	*Fresno*	4
Awtrey, H.,	*Fresno*	4
Axline, J. T.,	*North Hollywood*	10
Ayer, E. W.,	*Oakland*	1
Ayers, T. F.,	*San Francisco*	23
Ayres, S., Jr.,	*Los Angeles*	10
Ayres, W.,	*Los Angeles*	10
Azevedo, J. A.,	*Hayward*	1
Azevedo, J. L., Jr.,	*Modesto*	34
Azevedo, M. L.,	*Sacramento*	19

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NAME	CITY	COUNTY SOCIETY NO.
Babcock, D. W.,	*Placerville*	19
Babcock, E. S., Jr.,	*Sacramento*	19
Babcock, J. W.,	*Placerville*	19
Babcock, L. G.,	*Vernon*	10
Babcock, R. A.,	*Willits*	12
Babienco, A. T.,	*San Diego*	22
Babington, S. H.,	*Berkeley*	1
Baccus, C. F.,	*Hollywood*	10
Bacher, J. A.,	*San Francisco*	23
Bachhuber, C. A.,	*Los Angeles*	10
Bachmann, G. W.,	*Santa Monica*	10
Bachrach, R. J.,	*Salinas*	29
Bacigalupi, A. A. J.,	*San Francisco*	23
Bacon, L. C.,	*Los Angeles*	10
Bacon, S. K.,	*Hollywood*	10
Baer, H.,	*Elsinore*	18
Baetz, W. G.,	*Huntington Park*	10
Bahrenburg, G. E.,	*Bakersfield*	7
Bailey, C. A.,	*Los Angeles*	10
Bailey, C. O.,	*Los Angeles*	10
Bailey, F. J.,	*Red Bluff*	35
Bailey, T. E.,	*San Francisco*	23
Bailey, W.,	*Los Angeles*	10
Bailey, W. E.,	*Los Angeles*	10
Baiocchi, A. J.,	*San Jose*	28
Baird, C.,	*San Bernardino*	21
Baird, C. G.,	*Santa Maria*	27
Baird, H. R.,	*Sacramento*	19
Baird, M. N.,	*Redondo Beach*	10
Bak, E. W.,	*Los Angeles*	10
Baker, C. D.,	*Los Angeles*	10
Baker, F.,	*San Francisco*	23
Baker, G. L.,	*San Francisco*	23
Baker, H. V.,	*Napa*	15
Baker, J. J.,	*West Los Angeles*	10
Baker, M. D.,	*San Jose*	28
Baker, R. W.,	*Sunland*	10
Baker, W.,	*Los Angeles*	10
Baker, W. P.,	*Santa Ana*	16
Bakewell, B.,	*Santa Barbara*	27
Bakke, G. A.,	*Oakland*	1
Baldwin, A. K.,	*Long Beach*	10
Baldwin, L. G.,	*Pasadena*	10
Baldwin, M. C.,	*Riverside*	18
Ball, D. R.,	*Santa Ana*	16
Ball, E. J.,	*Los Angeles*	10
Ball, F. I.,	*Los Angeles*	10
Ball, H. A.,	*San Diego*	22
Ball, J. D.,	*Santa Ana*	16
Ballard, C. H.,	*Santa Monica*	10
Ballard, S. E.,	*Long Beach*	10
Balyeat, F. S.,	*Los Angeles*	10
Bames, H. O.,	*Los Angeles*	10
Bancroft, I. R.,	*Los Angeles*	10
Bandelier, R. H.,	*Los Angeles*	10
Banks, A. E.,	*San Diego*	22
Banks, E. F.,	*Loomis*	17
Banks, G. F.,	*San Diego*	22
Banks, W. H.,	*San Francisco*	23
Barbanell, R. R.,	*Los Angeles*	10
Barber, E. M.,	*Oakland*	1
Barber, P. S.,	*Porterville*	36
Barbour, N. P.,	*Stockton*	24
Barclay, H. A.,	*San Diego*	22
Bardfill, J. W.,	*Ventura*	37
Barkan, H.,	*San Francisco*	23
Barkan, O.,	*San Francisco*	23
Barker, H. E.,	*Ventura*	37
Barker, J. L.,	*Brawley*	6
Barlow, T. H.,	*Long Beach*	10
*Barlow, W. J.,	*Los Angeles*	10
Barmore, M. G.,	*Calexico*	6
Barnard, F. S.,	*Los Angeles*	10
Barnard, H. D.,	*Los Angeles*	10
Barnard, H. D.,	*Los Angeles*	10
Barnard, L. B.,	*Oakland*	1
Barnes, J. W.,	*Stockton*	24
Barnes, L. B.,	*Newcastle*	17
Barnes, P. D.,	*Loomis*	17
Barnes, R. W.,	*Los Angeles*	10
Barnes, S. D.,	*Los Angeles*	10
Barnes, W. H.,	*Chico*	2
Barnett, C. W.,	*San Francisco*	23
Barnett, E. D.,	*Santa Rosa*	33
Barnett, G. D.,	*San Francisco*	28
Barnhart, W.,	*Los Angeles*	10
Baron, P. P.,	*Alameda*	1
Barr, A. L.,	*San Diego*	22
Barr, W. T.,	*Fresno*	4
Barrett, G. M.,	*San Francisco*	23
Barrette, L. C.,	*Sacramento*	19
Barrette, P. C.,	*San Jose*	28
Barron, A.,	*Stockton*	24
Barron, H. C., Jr.,	*Escondido*	22
Barrow, J. V.,	*Los Angeles*	10
Barrow, W. H.,	*San Diego*	22
Barry, G. L.,	*San Jose*	28
Bartle, I. B.,	*San Luis Obispo*	25
Bartholomew, J. Y.,	*San Francisco*	23
Bartholomew, T. E.,	*Calexico*	6
Bartlett, C. L.,	*Pasadena*	10
Bartlett, E. I.,	*San Francisco*	23
Barton, E. W.,	*Alhambra*	10
Bascom, F. S.,	*Oakland*	1
Bates, C. E. H.,	*San Francisco*	23
Bathurst, E. W.,	*Etna*	31
Batson, W. C.,	*Greenville*	9
Baughman, W. H.,	*Oakland*	1
Baumgartner, C. J.,	*Los Angeles*	10
Bautista, M. D.,	*Stockton*	24
Baxter, C. P.,	*San Diego*	22
Baxter, F. S.,	*Oakland*	1
Baxter, P. N.,	*Oakland*	1
Bay, M. W.,	*Los Angeles*	10
Bay, S. G.,	*West Los Angeles*	10
Bayer, L. M.,	*San Francisco*	23
Bayley, W. A.,	*Los Angeles*	10
Baylis, J. N.,	*San Bernardino*	21
Beach, E. W.,	*Sacramento*	19
Beall, M. E.,	*Patton*	21
Bear, N. K.,	*Riverside*	18
Beard, E. A.,	*Inglewood*	10
Beardslee, A.,	*San Francisco*	23
Beardsley, J. R.,	*San Diego*	22
Beasley, E. M.,	*Santa Ana*	16
Beasley, H. E.,	*Glendale*	10
Beattie, J. I.,	*San Jose*	28
Beattie, W. A.,	*Sacramento*	19
Beatty, H. J.,	*Clinton, New Jersey*	10
Beatty, J. D.,	*Los Angeles*	10
Beauchamp, H. H.,	*Sacramento*	19
Beaudoux, H. A.,	*Los Gatos*	1
Beaver, H. J.,	*Palo Alto*	28
Beaver, M. G.,	*Redlands*	21
Beck, G. H.,	*Glendale*	10
Beck, H. H.,	*Corning*	35
Beck, H. R.,	*Los Angeles*	10
Beck, J. A.,	*Salinas*	14
*Beck, J. E.,	*Tulare*	36
Becka, S. J.,	*Los Angeles*	10
Becker, G. H.,	*San Francisco*	23
Becker, H. F.,	*Los Angeles*	10
Becker, W. A.,	*Los Angeles*	10
Becker, W. N.,	*Sacramento*	19
Beckett, W. A.,	*Los Angeles*	10
Beckh, W.,	*San Francisco*	23
Beckstrand, G.,	*Long Beach*	10
Bedri, M. R.,	*Los Angeles*	10
Beebe, J. L.,	*Anaheim*	16
Beebe, L. J.,	*Santa Rosa*	27
Beede, A. H.,	*Walnut Creek*	3
Beekler, A. M.,	*Santa Maria*	27
Beem, M. D.,	*West Los Angeles*	10
Beerman, H. M.,	*Los Angeles*	10
Beerman, W. F.,	*San Francisco*	23
Beeson, H. O.,	*San Bernardino*	21
Behne, K. F.,	*Los Angeles*	10
Behneman, H. M. F.,	*San Francisco*	23
Behrendt, R. A.,	*Los Angeles*	10
Beigelman, M.,	*Los Angeles*	10
Beil, M. C.,	*Upper Lake*	12
Belford, W. W.,	*San Diego*	22
Bell, D. P.,	*Oakland*	1
Bell, H. G.,	*San Francisco*	23
Bell, H. W.,	*Bakersfield*	7
*Bell, M. T.,	*Ventura*	37
Bell, T. F.,	*Oakland*	1
Bell, W. L.,	*Oakland*	1
Bellin, J. J.,	*Los Angeles*	10
Belous, L. P.,	*Los Angeles*	10
Belove, B.,	*Los Angeles*	10
Belt, A. E.,	*Hollywood*	10
Belt, R. L.,	*Montrose*	10
Beltz, D.,	*Lodi*	24
Bender, W. L.,	*San Francisco*	23
Bendlage, G. A.,	*Long Beach*	10
Benner, E. A.,	*San Mateo*	26
Bennett, C. B.,	*Berkeley*	1
Bennett, C. L.,	*Los Angeles*	10
Bennett, C. R.,	*Compton*	10
Bennett, D. W.,	*San Francisco*	23
Bennett, E. L.,	*Long Beach*	4
Bennett, E. S.,	*Olive View*	10
*Bennett, L. B.,	*San Pedro*	10
Bennett, L. C.,	*Los Angeles*	10
Bennett, M. C.,	*Berkeley*	1
Bennett, M. G. E.,	*El Monte*	10
Bennett, W. W.,	*Los Angeles*	10
*Bennette, M. A.,	*San Bernardino*	21
Bennetts, F. A.,	*Los Angeles*	10
Benninger, C., Jr.,	*Oroville*	2
Benninghoven, C. D.,	*San Mateo*	26
Benson, C. B.,	*Modesto*	34
Benson, E. H., Jr.,	*Berkeley*	1
Benton, J. J.,	*Oakland*	1
Bepler, A. C.,	*San Francisco*	23
Berauer, J. M.,	*Los Angeles*	10
Berg, A.,	*San Francisco*	23
Berg, G. O.,	*Hollywood*	10
Berge, F. E.,	*Los Angeles*	10
Berger, A. A.,	*San Francisco*	23
Bergman, R. T.,	*Los Angeles*	10
Bergmann, J. E.,	*Santa Monica*	10
Bergstrom, F. K.,	*Los Angeles*	10
Berkes, H. A.,	*Hollywood*	10
Berkley, H. K.,	*Los Angeles*	10
Berkove, A. B.,	*Oakland*	1
Berkove, S. E.,	*Oakland*	1
Berman, P.,	*Los Angeles*	10
Bernardini, C. V.,	*San Diego*	22
Berne, C. J.,	*Los Angeles*	10
Bernstein, A.,	*San Francisco*	23
Bernstein, M. M.,	*Los Angeles*	10
Bertero, J.,	*Santa Maria*	27
Best, E. J.,	*San Francisco*	23
Bettercourt, M. F.,	*Watsonville*	29
Bettin, M. E.,	*Los Angeles*	10
Bettman, J. W.,	*San Francisco*	23
Betts, I. H.,	*Visalia*	36
Bewley, M. H.,	*Los Angeles*	10
Bicknell, H. E.,	*Long Beach*	10
Bieler, H. G.,	*Pasadena*	10
Bigler, A. B.,	*Chowchilla*	13
Bilker, D.,	*San Jose*	28
Bill, P. R.,	*San Francisco*	23
Billig, H. E., Jr.,	*Los Angeles*	10
Billingsley, U. C.,	*Hayward*	1
Bilon, L. V.,	*Los Angeles*	10
Bine, R.,	*San Francisco*	23
Bingaman, E. W.,	*Salinas*	14
Bingaman, W. H.,	*Salinas*	14
Bingham, E.,	*Woodland*	38
Binkley, R. W.,	*Selma*	4
Binkley, T.,	*Sacramento*	19
Bird, A. A.,	*San Leandro*	1
Bird, W. A.,	*Pasadena*	10
Birkenstock, C. F.,	*San Diego*	22
Birnbaum, W. D.,	*San Francisco*	23
Bishop, C. R.,	*Long Beach*	10
Bishop, T. E.,	*San Diego*	22
Bishop, T. W.,	*S. Pasadena*	10
Bittner, C. L.,	*Sacramento*	19
Bittner, L. H.,	*Glendale*	10
Bittner, S. P.,	*Glendale*	10

NAME	CITY	COUNTY SOCIETY NO.
Black, B. W.,	*Oakland*	1
Black, E. C.,	*San Diego*	22
Black, H.,	*Palo Alto*	28
Blackfield, H. M.,	*San Francisco*	23
Blackman, W. H.,	*Indio*	18
Blackmun, E. L.,	*Stockton*	24
Blackmun, R. L.,	*Los Angeles*	10
Blackshaw, J. B.,	*Sonoma*	33
Blahnik, K. B.,	*Pasadena*	10
Blaine, E. S.,	*Los Angeles*	10
Blaisdell, F. E., Jr.,	*Watsonville*	29
Blaisdell, P. C.,	*Pasadena*	10
Blake, C. R.,	*Richmond*	3
Blake, K. W.,	*Los Angeles*	10
Blanchard, T. L.,	*San Jose*	28
Bland, C.,	*Laguna Beach*	10
Blank, B.,	*Los Angeles*	10
Blatherwick, A. A.,	*Los Angeles*	10
Blatherwick, G. W.,	*Los Angelcs*	10
Blecker, R. F.,	*Fresno*	4
Bledsoe, R. W. E.,	*Los Angeles*	10
Blemer, J. W.,	*Diablo*	3
Blevins, W. J.,	*Woodland*	38
Blevins, W. J., Jr.,	*Woodland*	38
Blinn, J. F.,	*Stockton*	24
Bliss, G. L.,	*Long Beach*	10
Bliss, W. P.,	*Pasadena*	10
Bloch, J. L.,	*San Pedro*	10
Blodgett, H. H.,	*Beverly Hills*	10
Blodgett, W. LeR.,	*Calistoga*	15
Blond, H. H.,	*Los Angeles*	10
Blondin, E. A.,	*San Diego*	22
Blong, P. H.,	*Alhambra*	10
Blood, J. N.,	*Redwood City*	26
Bloomfield, A. L.,	*San Francisco*	23
Blossom, H. S.,	*Patton*	21
Blum, S.,	*San Francisco*	23
Blumenthal, E. L.,	*Oakland*	1
Boardman, W. W.,	*San Francisco*	23
Bobbitt, A. N.,	*Pasadena*	10
Bobbitt, J. D.,	*San Diego*	22
Bock, C.,	*Los Angeles*	10
Boder, E.,	*Los Angeles*	10
Bodlander, J. W.,	*Los Angeles*	10
Bodman, E. W.,	*Pasadena*	10
Bodner, H.,	*Hollywood*	10
Boe, M. R.,	*Alameda*	1
Boeck, W. C.,	*Los Angeles*	10
Boehm, C. A.,	*San Francisco*	23
Boehm, M.,	*Napa*	15
Boehmer, A. C.,	*Lodi*	24
Boericke, C. C.,	*Berkeley*	1
Boess, E. C.,	*Riverside*	18
Boetticher, E. O.,	*Los Angeles*	10
Boge, H. G. C.,	*Oakland*	1
Bogen, E.,	*Olive View*	10
Bogle, S. S.,	*Santa Rosa*	33
Bohm, J. E., Jr.,	*San Francisco*	23
Bolander, L. P.,	*Van Nuys*	10
Bolender, M. C.,	*Walnut Creek*	3
Boles, A.,	*Oakland*	1
Bolin, Z. E.,	*San Francisco*	23
Bolinger, H. J.,	*Lodi*	24
Boller, S.,	*Los Angeles*	10
Bollig, H. L.,	*Los Angeles*	10
Bolognino, O. J.,	*San Francisco*	23
Bolstad, H. C.,	*Oakland*	1
Bolze, E. H.,	*San Francisco*	23
Bonar, P. A.,	*San Francisco*	23
Bond, A. L.,	*Lindsay*	36
Bond, E. C.,	*Hanford*	8
Bond, F. M.,	*San Diego*	22
Bond, R. E.,	*San Diego*	22
Bonesteel, H. T. S.,	*Los Angeles*	10
Bonfiglio, J.,	*Hollywood*	10
Bonfiglio, V.,	*Los Angeles*	10
Bonn, H. K.,	*Los Angeles*	10
Bonoff, K. M.,	*Los Angeles*	10
Bonthius, A.,	*Pasadena*	10
Bonura, F.,	*Los Angeles*	10
Bonynge, C. W.,	*Los Angeles*	10
Boone, W. R.,	*Berkeley*	1
Boonshaft, L.,	*Los Angeles*	10
Booth, M. M.,	*St. Helena*	15
Borden, F. W.,	*San Jose*	28
Borley, R. D.,	*Half Moon Bay*	26
Borley, W. E.,	*San Francisco*	23
Bormann, G. B.,	*Hollywood*	10
Boscoe, A. R.,	*Sacramento*	19
Boscoe, C. T.,	*Oakland*	1
Boskowitz, G. H.,	*San Francisco*	23
Bost, C.,	*San Francisco*	23
Bost, F. C.,	*San Francisco*	23
Bosworth, H. W.,	*Los Angeles*	10
Bothe, R. T.,	*Springfield, Ill.*	22
Botsford, M. E.,	*San Francisco*	23
Bourbon, O. P.,	*Los Angeles*	10
Bowen, A.,	*Los Angeles*	10
Bowen, C. B.,	*Oakland*	1
*Bowen, F. P.,	*Los Angeles*	10
Bower, A. G.,	*Hollywood*	10
Bower, C. F.,	*Long Beach*	10
Bowers, C. H.,	*Los Angeles*	10
Bowers, P. E.,	*Los Angeles*	10
Bowers, W. S.,	*Los Angeles*	10
Bowles, A. M.,	*Santa Rosa*	33
Bowles, F. H.,	*Oakland*	1
Bowman, P.,	*West Los Angeles*	10
Bowman, P. J.,	*Fort Bragg*	12
Bowman, R. J.,	*Los Angeles*	10
Boyce, L.,	*Los Angeles*	10
Boyce, W. A.,	*Los Angeles*	10
Boyd, E. F.,	*Los Angeles*	10
Boyd, E. G.,	*Los Angeles*	10
Boyd, H. W.,	*Los Angeles*	10
Boyd, R. T.,	*San Francisco*	23
Boyd, T. O.,	*Long Beach*	10
Boyd, W. H.,	*Long Beach*	10
Boyer, H. R.,	*Glendale*	10
Boyer, J. L.,	*Long Beach*	10
Boyer, K. H.,	*Los Angeles*	10
Boyers, L. M.,	*Berkeley*	1
Boyle, S. F.,	*San Francisco*	23
Bradford, F. E.,	*Los Angeles*	10
Brady, A. L.,	*San Rafael*	11
Brady, J. F.,	*Alameda*	1
Braithwaite, W. W.,	*Beverly Hills*	10
Bramhall, R. N.,	*Sacramento*	19
Bramkamp, A. L.,	*Banning*	18
Bramwell, H. L.,	*Napa*	15
Bramwell, L.,	*Lake Arrowhead*	21
Branch, W. E.,	*Los Angeles*	10
Brandel, H. M.,	*Los Angeles*	10
Brandenburg, K. C.,	*Long Beach*	10
Brandes, L.,	*Los Angeles*	10
Brandt, F. H.,	*Los Angeles*	10
Brandt, G. C.,	*Los Angelcs*	10
Brannon, M.,	*Merced*	13
Bransford, S. G.,	*Suisun*	32
Bransford, M. B.,	*Vallejo*	32
Brastad, J. P.,	*Anaheim*	16
Brazelton, H.,	*Oakland*	1
Breck, L. W.,	*Rochester, Minn.*	11
Breitman, H. B.,	*Los Angeles*	10
*Brem, W. V.,	*Los Angeles*	10
Breslin, F. J.,	*Los Angeles*	10
Breuer, C. H.,	*San Jose*	28
Breuer, R. G.,	*San Jose*	28
Breyer, J. H.,	*Pasadena*	10
Bricca, C. R.,	*San Francisco*	23
Bricca, E. C.,	*San Francisco*	23
Bridgman, J. G.,	*San Mateo*	26
Bridgman, O.,	*San Francisco*	23
Bridgman, W. R.,	*Hanford*	8
Briggs, C. H.,	*Pasadena*	10
Briggs, G. A.,	*Sacramento*	19
Briggs, LeR. H.,	*San Francisco*	23
Briggs, W. M.,	*Monrovia*	10
Briggs, W. R.,	*Sacramento*	19
Brigham, E.,	*Dinuba*	36
Brigham, F. O.,	*Los Angeles*	10
Brill, J.,	*Long Beach*	10
Brinckerhoff, E. E.,	*Oakland*	1
Brink, H. E.,	*Lower Lake*	12
Brinkman, W. F.,	*Long Beach*	10
Briner, C. C.,	*Auburn*	17
Broaddus, C. A.,	*Stockton*	24
Brock, L. H.,	*San Francisco*	23
Brockow, J. L.,	*Los Angeles*	10
Brockway, A.,	*Los Angeles*	10
Brodovsky, D.,	*San Jose*	28
Broemser, M. A.,	*San Jose*	28
Bronfeld, N.,	*Los Angeles*	10
Brooks, C. S.,	*El Centro*	6
Brooks, E. R.,	*Atascadero*	1
Brooks, H. T.,	*Alhambra*	10
Brooks, LeR.,	*San Francisco*	23
Bross, R. B.,	*Santa Monica*	10
Broughton, G. A.,	*Ventura*	37
Brown, A. F.,	*Los Angelcs*	10
Brown, A. L.,	*Riverside*	18
Brown, A. L.,	*San Francisco*	23
Brown, B.,	*Sacramento*	19
Brown, B. C.,	*Los Angeles*	10
Brown, B. H.,	*San Ysidro*	22
Brown, B. P.,	*Los Angeles*	10
Brown, C.,	*San Francisco*	23
Brown, C. M.,	*Los Angeles*	10
Brown, C. W.,	*San Diego*	22
Brown, C. W.,	*San Diego*	22
Brown, D. F.,	*Redwood City*	26
Brown, E. O.,	*Sacramento*	19
Brown, F. A.,	*Hayward*	1
Brown, F. E.,	*Los Angelcs*	10
Brown, G. B.,	*Oakland*	1
Brown, G. D.,	*Pomona*	10
Brown, G. W.,	*Los Angeles*	10
Brown, H. A.,	*Berkeley*	1
Brown, H. A.,	*San Francisco*	23
Brown, H. C.,	*San Jose*	28
Brown, H. L.,	*Los Angelcs*	10
*Brown, H. V.,	*Glendale*	10
Brown, I. De Y.,	*Inglewood*	10
Brown, J. M.,	*Los Angeles*	10
Brown, J. M.,	*Ferndale*	5
Brown, J. R.,	*Los Angeles*	10
Brown, L. E.,	*Corona*	18
Brown, M. H.,	*Los Angeles*	10
*Brown, N. N.,	*Bakersfield*	7
Brown, P. K.,	*San Francisco*	23
Brown, R.,	*Santa Barbara*	27
Brown, R.,	*San Francisco*	23
Brown, R. H.,	*Pasadena*	10
Brown, T. H.,	*Orland*	38
Brown, W. E.,	*Los Angeles*	10
Brown, W. H.,	*Palo Alto*	28
Browne, F. E.,	*Los Angeles*	10
Browne, G. C.,	*Oakland*	1
Brownfield, W. H.,	*Los Angeles*	10
Browning, C. F.,	*Los Angeles*	10
Brownlie, J. W.,	*Vallejo*	32
Brownsberger, C. N.,	*Glendale*	10
Brownsberger, S. B.,	*Los Angeles*	10
Bruck, E. L.,	*San Francisco*	23
Bruckman, F. S.,	*San Francisco*	23
Bruckman, H.,	*San Jose*	28
Bruechert, S. S.,	*Hondo*	10
Bruff, W. C.,	*Whittier*	10
Bruin, M. R.,	*Los Angeles*	10
Brull, A.,	*Los Angeles*	10
Bruman, A. K.,	*San Francisco*	23
Brumbaugh, D. H.,	*Redlands*	21
Brumwell, D.,	*King City*	14
Brunemeier, E. H.,	*Placentia*	16
Brunie, L. J.,	*Pasadena*	10
Brunie, Y. S.,	*Pasadena*	10
Bruning, E. F.,	*Santa Ana*	16
Brunn, H.,	*San Francisco*	23
Brusco, H. D.,	*San Francisco*	23
Brush, N. H.,	*Santa Barbara*	27
Brust, P. R.,	*San Diego*	22
Bryan, L.,	*San Francisco*	23
Bryant, B. L.,	*Los Angeles*	10
Bryant, D. C.,	*Claremont*	10
Bryant, H. E.,	*Los Angeles*	10
Buchanan, R. A.,	*Lodi*	24
Buchner, G. O. H.,	*Bakersfield*	7
Buck, L. W.,	*Ross*	23
Buckell, A. E. T.,	*Oakland*	1
Buckingham, J. R.,	*Los Angeles*	10
Buckley, T. I.,	*Oakland*	1
Bucknam, R. W. E.,	*Hollywood*	10
Budd, G. J.,	*Vallejo*	32
Budd, J. W., Jr.,	*Los Angeles*	10
Budge, E. S.,	*Los Angeles*	10
Bull, E. C.,	*San Francisco*	23
Bullard, C. T.,	*King City*	14
Bulley, E. W.,	*Gustine*	13
Bullis, J. A. E.,	*Los Angeles*	10
Bullis, R. O.,	*Los Angeles*	10
Bullitt, J. B.,	*San Jose*	28
Bullock, A. S.,	*Alhambra*	10
Bullock, L. T.,	*Los Angeles*	10
Bulpitt, H. G.,	*Santa Monica*	10
Bulpitt, J. M.,	*Santa Ana*	16
Bulpitt, P. A.,	*Santa Monica*	10
Bulpitt, Z. E. N.,	*Santa Ana*	16
Bulson, C. H.,	*Napa*	15
Bumgarner, J. W.,	*Richmond*	3
Bumpus, H. C.,	*Pasadena*	10
Bumpus, L. D.,	*Beverly Hills*	10
Bunch, C. C.,	*Los Angeles*	10
Bunnell, S.,	*San Francisco*	23
Bunney, G.,	*Santa Cruz*	29
Burby, J. J.,	*Los Angeles*	21
Burchardi, K. G. H.,	*Los Angeles*	10
Burchfiel, C. M.,	*San Jose*	28
Burden, H. S.,	*Sacramento*	19
Burgan, J. H.,	*Los Angeles*	10
Burge, M. H.,	*Los Angeles*	10
Burger, F. A.,	*El Centro*	6
Burger, T. O.,	*San Diego*	22
Burk, E. E.,	*Los Angeles*	10
Burkard, A. F.,	*Santa Barbara*	27
Burke, A. M. B.,	*Alameda*	1
Burke, D. V.,	*Oakland*	1
Burke, E. W.,	*Redlands*	21
Burke, G. R.,	*Alameda*	1
Burke, G. T.,	*Pasadena*	10
Burkelman, A.,	*Los Angeles*	10
Burkett, R. C.,	*Napa*	15
Burkhard, W. G.,	*San Francisco*	23
Burks, F. L. R.,	*Fresno*	4
Burlew, J. M.,	*Santa Ana*	16
Burlingame, R. W.,	*San Francisco*	23
Burnap, S. R.,	*Los Angeles*	10
Burnett, C. I.,	*Susanville*	9
Burnham, C. J.,	*Berkeley*	1
Burnham, C. J., Jr.,	*Berkeley*	1
Burnham, DeW. K.,	*San Francisco*	23
Burnham, P. S.,	*Los Angeles*	10
Burns, E. M.,	*Huntington Park*	10
Burns, G. C.,	*Los Angeles*	10
Burns, J. E.,	*Huntington Park*	10
Burns, M. B.,	*Los Angeles*	10
Burns, T. S.,	*San Francisco*	23
Burnside, C.,	*Hollywood*	10
Burrall, G. M.,	*Los Angeles*	10
Burre, S. P.,	*Eureka*	5
Burroughs, P. R.,	*Santa Monica*	10
Burrows, C. A.,	*Los Angeles*	10
Burrows, J. R.,	*San Francisco*	23
Burrows, L. A.,	*Los Angeles*	10
Burrows, M. T.,	*Pasadena*	10
Bursell, A.,	*Mountain View*	28
Burtness, H. I.,	*Santa Barbara*	27

NAME	CITY	COUNTY SOCIETY NO.
Burton, F. A.,	*San Diego*	22
Burton, W. T.,	*Tulare*	36
Burwell, L. C.,	*Los Angeles*	10
*Busby, J. L.,	*Pasadena*	10
Bush, H. C.,	*Livermore*	1
Bussey, D. G.,	*Avalon*	10
Butka, L. J.,	*Alhambra*	10
Butler, E.,	*San Francisco*	23
Butler, F. O.,	*Eldridge*	33
Butler, J. B. V.,	*San Luis Obispo*	25
Butler, K. W.,	*Madera*	4
Butler, O. W.,	*Los Angeles*	10
Butler, W. D.,	*San Luis Obispo*	25
Butt, E. G.,	*Redondo Beach*	10
Butt, E. M.,	*Los Angeles*	10
Butterfield, A. DeF.,	*Loma Linda*	21
Butterfield, E. R.,	*Burbank*	10
Byars, A. H.,	*San Diego*	22
Byers, W. M.,	*Van Nuys*	10
Byington, P. C.,	*Modesto*	34
Byron, R. L.,	*Los Angeles*	10
Byron, W. P.,	*Lemoore*	8

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Cadwell, E.,	*Fontana*	21
Cady, D. W.,	*Pasadena*	10
Cady, F. P.,	*Los Angeles*	10
Cahen, C. G.,	*Los Angeles*	10
Cain, E. F.,	*Anaheim*	16
Cain, W. T.,	*Gardena*	10
Calahan, L. J.,	*Lower Lake*	12
Calaway, A. A.,	*Fresno*	4
Caldwell, G. W.,	*Los Angeles*	10
Caldwell, H. M.,	*La Canada*	10
Callander, C. L.,	*San Francisco*	23
Callaway, J. W.,	*La Jolla*	22
Callaway, W. O.,	*Burlingame*	26
Calvert, E. H.,	*San Diego*	22
Calvin, G. F.,	*Oakland*	1
Cameron, A. C.,	*Los Angeles*	10
Cameron, L. C.,	*Santa Ana*	16
Cameron, M. C.,	*Los Angeles*	10
Cameron, W. A.,	*So. Pasadena*	10
Camp, J. W.,	*La Habra*	16
Campbell, C. C.,	*Long Beach*	10
Campbell, C. R.,	*San Jose*	28
Campbell, D. McL.,	*San Francisco*	23
Campbell, G. E.,	*Pasadena*	10
Campbell, G. M.,	*Southgate*	10
Campbell, H. G.,	*Lindsay*	36
Campbell, H. S.,	*Los Angeles*	10
Campbell, J. R. U.,	*Dunsmuir*	31
Campbell, J. V.,	*Oakland*	1
Campbell, L. D.,	*San Jose*	28
Campbell, L. G.,	*Pasadena*	10
Campbell, M.,	*Los Angeles*	10
Campbell, F. McL.,	*San Pedro*	10
Campbell, M. P.,	*San Francisco*	23
Campbell, R.,	*Los Angeles*	10
Campbell, R. A.,	*Los Angeles*	10
Campbell, W. M.,	*Sacramento*	19
Campiche, P. S.,	*San Francisco*	23
Campion, E.,	*San Francisco*	23
Canby, C. B.,	*Van Nuys*	10
Canelo, C. K.,	*San Jose*	28
Canfield, M. C.,	*El Centro*	6
Canfield, M. N.,	*Redlands*	21
Cannon, F. M.,	*San Rafael*	11
Cantarow, J. H.,	*Los Angeles*	10
Cantoni, A. J.,	*San Diego*	22
Capp, C. S.,	*San Francisco*	23
Card, J. F.,	*San Francisco*	23
Card, T. A.,	*Riverside*	18
Carden, J. J.,	*Honolulu, T. H.*	1
*Carey, H. B.,	*San Francisco*	23
Carey, T. S.,	*Los Angeles*	10
Carey, W. W.,	*Gridley*	2
Carhart, E. C.,	*Hollywood*	10
Carlile, M. N.,	*Lakeside*	22
Carlson, C. M.,	*Santa Rosa*	33
Carlson, E.,	*San Francisco*	23
Carlson, E. F.,	*Fort Jones*	31
Carlson, F. J.,	*Oakland*	1
Carmack, J. C.,	*San Bernardino*	21
Carmichael, H.,	*Sacramento*	19
Carpenter, F. L.,	*Berkeley*	1
Carpenter, H. C.,	*Berkeley*	1
Carpenter, H. L.,	*Richmond*	3
Carr, J. L.,	*San Francisco*	23
Carroll, R. L.,	*Los Angeles*	10
Carroll, W. A.,	*San Francisco*	23
Carson, A. B.,	*Oakland*	1
Carson, D. A.,	*San Francisco*	23
Carson, G. R.,	*San Francisco*	23
Carter, A. E.,	*North Hollywood*	10
Carter, C. E.,	*Pasadena*	10
Carter, F. H.,	*San Diego*	22
Carter, H. R.,	*San Pedro*	28
Carter, M. G.,	*Los Angeles*	10
Carter, R. A.,	*Los Angeles*	10
Carter, R. A.,	*Los Angeles*	10
Carter, R. H.,	*Fresno*	4
Carter, R. S.,	*San Diego*	22
Carter, R. V.,	*Santa Monica*	27
Carter, W. E.,	*San Francisco*	1
Carter, W. N.,	*Los Angeles*	10
Cartmell, T. M.,	*Los Angeles*	10
Caruso, T. D.,	*Los Angeles*	10
Carver, W. F., Jr.,	*Hollywood*	10
Cary, J. A.,	*Crockett*	3
Cary, R. J.,	*Long Beach*	10
Cary, W. S.,	*San Francisco*	23
Case, C. E.,	*Santa Maria*	27
Case, L. W.,	*Pomona*	10
Casey, H. A.,	*Oakland*	1
Casey, T. J.,	*Oakland*	1
Caskey, C. R.,	*Los Angeles*	10
Caspar, P. C.,	*Hollywood*	10
Cass, A. B.,	*Los Angeles*	10
Cass, D.,	*Los Angeles*	10
Cassady, E. S.,	*San Pedro*	10
Cassell, I.,	*San Jose*	28
Cassidy, F. C.,	*Livermore*	1
Castlehun, P.,	*San Francisco*	23
Castlen, C. R.,	*Glendale*	10
Cates, H. B.,	*Los Angeles*	10
Catton, J.,	*San Francisco*	23
Cavanaugh, L. A.,	*West Los Angeles*	27
Cecil, A. B.,	*Los Angeles*	10
Cecil, J. J.,	*Patton*	21
Cerf, A. E.,	*San Francisco*	23
Chabanoff, E.,	*San Francisco*	23
Chaffee, B. S.,	*Long Beach*	10
Chaffin, G. L.,	*Los Angeles*	10
Chaffin, R. C.,	*Los Angeles*	10
Chaiken, L. H.,	*San Jose*	28
Chalmov, A. S.,	*San Francisco*	23
Chain, J. N.,	*Eureka*	5
Chain, J. S.,	*Eureka*	5
Chalmers, J. F.,	*La Jolla*	22
Chaloupka, H. R.,	*Los Angeles*	10
Chamberlain, B. H.,	*Alhambra*	10
Chamberlain, E. F.,	*San Diego*	22
Chamberlin, H. H.,	*Glendora*	10
Chambers, S. O.,	*Los Angeles*	10
Chamlee, W. F.,	*Hanford*	8
Champion, J. A.,	*Colton*	21
Chandler, L. R.,	*San Francisco*	23
Chaney, L. A.,	*Los Angeles*	10
Channell, W. L.,	*Oakland*	1
Chapman, G. E.,	*San Francisco*	23
Chapman, H. J.,	*Los Angeles*	10
Chapman, H. S.,	*Stockton*	24
Chapman, J. F.,	*Pasadena*	10
Chapman, J. L.,	*Los Angeles*	10
Chapman, L. S.,	*Los Angeles*	10
Chapman, W. H.,	*Blythe*	18
Chappell, A. E.,	*Vallejo*	32
Chappell, G. E.,	*Sacramento*	19
Chappell, H. W.,	*Los Angeles*	10
Charles, H. L.,	*Alhambra*	10
Charlesworth, I. E.,	*Imola*	15
Charlton, A. T.,	*Whittier*	10
Charlton, C. F.,	*Pasadena*	10
Charmak, D. D.,	*San Francisco*	23
Charnock, D. A.,	*Los Angeles*	10
Chase, A. E.,	*Santa Ana*	16
Chase, A. S.,	*Los Angeles*	10
Chase, E. M.,	*Soledad*	14
Chase, F. H.,	*Los Angeles*	10
Chavannes, V. C.,	*No. Hollywood*	10
Chavez, M.,	*Los Angeles*	10
Cheney, G.,	*San Francisco*	23
Cheney, L. D.,	*Los Angeles*	10
Cheney, M. C.,	*Berkeley*	1
Cheney, W. F.,	*San Francisco*	23
Cherry, C. F.,	*Los Angeles*	10
Cherry, W. S.,	*Rialto*	21
Chesbro, E. J.,	*Gilroy*	28
Chessman, F. N.,	*Los Angeles*	10
Chiapella, J. O.,	*Chico*	2
Childress, M. H.,	*Ione*	19
Childrey, J. H.,	*Atherton*	26
Chilton, F. N.,	*San Jose*	28
Ching, P. S.,	*Fresno*	4
Chipman, E. D.,	*San Francisco*	23
Chipman, W. D.,	*Los Angeles*	10
Chouret, E. E.,	*Riverbank*	34
Christensen, A. C.,	*Glendale*	10
Christensen, E. L.,	*Los Angeles*	10
Christensen, G. E.,	*Los Angeles*	10
Christensen, W.,	*Los Angeles*	10
Christensen, W. M.,	*Eagle Rock*	10
Christeson, E. L.,	*Los Angeles*	10
Christian, J. T.,	*Sacramento*	19
Christian, S. G.,	*Sacramento*	19
Christie, R. C.,	*Long Beach*	10
Christierson, S. von,	*San Francisco*	23
Christman, P. W.,	*Sacramento*	19
Christopherson, E. H.,	*San Diego*	22
Church, C. H.,	*Berkeley*	1
Church, I. O.,	*Oakland*	1
Church, M. V.,	*Norwalk*	10
Churchill, A. G.,	*Coronado*	22
Churchill, J. F.,	*San Diego*	22
Cieri, S.,	*Oakland*	1
Cilley, H. A.,	*San Jose*	28
Citron, J. W.,	*Oakland*	1
Clark, A. G.,	*San Francisco*	23
Clark, C. W.,	*San Rafael*	11
Clark, D. G.,	*Santa Paula*	37
Clark, D. M.,	*Santa Barbara*	27
Clark, E. B.,	*Los Altos*	28
Clark, E. P.,	*Los Angeles*	10
Clark, F. A.,	*Riverside*	18
Clark, G. S.,	*Los Angeles*	10
Clark, H. E.,	*Monterey*	14
Clark, H. S.,	*Riverside*	18
Clark, I. S.,	*Long Beach*	10
Clark, J. A.,	*Gilroy*	28
Clark, J. W.,	*Santa Rosa*	33
Clark, L. J.,	*Hemet*	18
Clark, R. L.,	*Sacramento*	19
Clark, T. J.,	*Oakland*	1
Clark, V. G.,	*San Diego*	22
Clark, W. A.,	*Pasadena*	10
Clark, W. A.,	*Holtville*	6
Clark, W. F.,	*Los Angeles*	10
Clark, W. R. P.,	*San Francisco*	23
Clark, W. S.,	*Ventura*	37
Clarke, A. F.,	*Oakland*	1
Clarke, F. B.,	*Long Beach*	10
Clarke, R. M.,	*Los Angeles*	10
Clarke, W. T.,	*Los Angeles*	10
Clay, H. E.,	*San Francisco*	23
Clayton, J. H.,	*Los Angeles*	10
Cleary, E. W.,	*San Francisco*	23
Cleary, G. G.,	*San Francisco*	23
Cleave, D. C.,	*Belvedere*	23
Clecak, N. J.,	*Oakland*	1
Cleeves, M.,	*La Crescenta*	10
Clemmer, C. V.,	*San Marino*	10
Clemons, E. J.,	*Los Angeles*	10
Cline, J. W.,	*San Francisco*	23
Clock, C. J.,	*Redlands*	21
Close, F. M.,	*San Francisco*	23
Close, K. M.,	*Los Angeles*	10
Clough, F. E.,	*San Bernardino*	21
Clough, V. R.,	*Long Beach*	10
Coate, C. R.,	*Whittier*	10
Coate, J. D.,	*Oakland*	1
Coates, G. L., Jr.,	*Martinez*	3
Cobb, V. M.,	*Pasadena*	10
Cobbs, P. P.,	*Los Angeles*	10
Coblentz, L. B.,	*San Francisco*	23
Coblentz, Z. B.,	*San Francisco*	23
Cochran, G. H.,	*Los Angeles*	10
Cochran, G. V.,	*Oakland*	1
Cochran, R. C.,	*Yorba Linda*	16
Cocks, C. E.,	*Oakland*	1
Cody, B. A.,	*San Francisco*	23
*Coe, H. C.,	*Oakland*	1
Coeur-Barron, F. H.,	*Los Angeles*	10
Coffey, E. C.,	*Orland*	38
Coffey, G. C.,	*Ventura*	37
Coffey, S. E.,	*Orland*	38
Coffey, W. B.,	*San Francisco*	23
Coffin, H. W.,	*Los Angeles*	10
Coghlan, C. C.,	*Los Angeles*	10
Cohen, M.,	*San Francisco*	23
Cohen, P.,	*Santa Maria*	27
Cohn, A. L.,	*San Francisco*	23
Cohn, H. J.,	*San Francisco*	23
Cohn, J.,	*Los Angeles*	10
Cohn, M. L.,	*San Francisco*	23
Colburn, J. M.,	*Riverside*	18
Colby, E. F.,	*Bakersfield*	7
Colby, E. G.,	*San Diego*	22
Cole, E. R.,	*Sacramento*	19
Cole, W.,	*Long Beach*	10
Coleman, B. E.,	*Los Angeles*	10
Coleman, D. D.,	*Alhambra*	10
Coleman, E. H.,	*Fresno*	4
Coleman, F. D.,	*Los Angeles*	10
Coller, G. J.,	*Los Angeles*	10
Collins, C. D.,	*Fresno*	4
Collins, D. C.,	*Beverly Hills*	10
Collins, F. K.,	*Los Angeles*	10
Collins, J. L.,	*Turlock*	34
Collins, M. C.,	*Turlock*	34
Collins, R. F.,	*No. Hollywood*	10
Collis, W. H. L.,	*Stockton*	24
Collischonn, P.,	*San Francisco*	23
Colver, B. N.,	*Glendale*	10
Comfort, H. W.,	*Fortuna*	5
Commons, E. L.,	*Los Angeles*	10
Compton, C. S.,	*Bakersfield*	7
Comstock, B. W.,	*Los Angeles*	10
Comstock, D. D.,	*Los Angeles*	10
Comstock, T. R.,	*Los Angeles*	10
Condit, J. C.,	*Oakland*	1
Condit, J. D.,	*Pasadena*	10
Conforth, E. L.,	*Laguna*	16
Congdon, W. R.,	*Santa Cruz*	29
Conklin, C. M.,	*Glendale*	10
Conlan, F. J. S.,	*San Francisco*	23
Conlan, P. T.,	*Los Angeles*	10
Conley, W. T.,	*Los Angeles*	10
Conn, C. E.,	*Hollywood*	10
Connell, DeB. W.,	*Berkeley*	1
Connell, J. A.,	*Riverside*	18
Conner, A. W.,	*San Jose*	28
Connor, C. L.,	*San Francisco*	23
Conroy, B. J.,	*Fairfax*	11
Conroy, T. F.,	*Palo Alto*	28

NAME	CITY	COUNTY SOCIETY NO.
Conser, W. H.,	*Guadalupe*	27
Conzelmann, F. J.,	*Stockton*	24
Cooder, H. R.,	*Los Angeles*	10
Coodley, O.,	*Los Angeles*	10
Cook, C. S.,	*Los Angeles*	10
Cook, C. W.,	*Los Angeles*	10
Cook, E. J.,	*Los Angeles*	10
Cook, E. P.,	*San Jose*	28
Cook, J. D.,	*Olive View*	10
Cook, O. S.,	*Sacramento*	19
Cook, W. C.,	*Los Angeles*	10
Cook, W. P.,	*Los Angeles*	10
Cooke, A. B.,	*Los Angeles*	10
Cooke, W. C.,	*San Diego*	22
Cooley, C. L.,	*San Francisco*	23
Coon, G. W.,	*Riverside*	18
Cooper, A. J.,	*San Diego*	22
Cooper, B.,	*Arcata*	5
Cooper, C. L.,	*Los Angeles*	10
Cooper, C. M.,	*San Francisco*	23
Cooper, F. G.,	*Huntington Park*	10
Cooper, G. P.,	*Angels Camp*	24
Cooper, H. J.,	*Fresno*	4
Cooper, J. A.,	*Modesto*	34
Cooper, T. E.,	*Davis*	38
Cooper, W.,	*Palo Alto*	28
Copeland, E. K.,	*Woodland*	38
Copp, E. F. F.,	*La Jolla*	22
Corbin, D. E.,	*San Diego*	22
Cordes, F. C.,	*San Francisco*	23
Cordua, O. B.,	*San Diego*	22
Cornell, H. D.,	*San Diego*	22
Corneille, J. G.,	*Berkeley*	1
Cornett, W. F.,	*Pasadena*	10
Cornwall, T. W.,	*San Francisco*	23
Corr, W. P.,	*Riverside*	18
Cortright, C. B.,	*Berkeley*	1
Cosgrove, C. P.,	*Los Angeles*	10
Cosgrove, J. B.,	*Los Angeles*	10
Coshow, G. H.,	*Carpinteria*	27
Costa, F. J.,	*San Pedro*	10
Costolow, W. E.,	*Los Angeles*	10
Cottle, C. C.,	*Los Angeles*	10
Cottrell, C. C.,	*Scotia*	5
Cottrell, E. L.,	*San Jose*	28
Cottrell, J. C.,	*Long Beach*	10
Coucy, E. J.,	*Fresno*	4
Coughlin, J. H.,	*San Bernardino*	21
Coulter, J. D.,	*Portola*	9
Counter, C. E.,	*Loma Linda*	21
Counter, H. M.,	*Buena Park*	16
Courtright, L. J.,	*San Francisco*	23
Courville, C. B.,	*Los Angeles*	10
Covault, W. I.,	*Costa Mesa*	16
Cowan, A. B.,	*Fresno*	4
Cowan, C. B.,	*San Francisco*	23
Cowgill, C. H.,	*Huntington Park*	10
Cowin, C. C.,	*Hollywood*	10
Cowles, D. C.,	*Fullerton*	16
Cox, A. J., Jr.,	*San Francisco*	23
Cox, B. E.,	*Coalinga*	4
Cox, E. R.,	*Los Angeles*	10
Cox, G. W.,	*San Francisco*	23
Cox, J. E.,	*Coalinga*	4
Cox, T. J.,	*San Francisco*	23
Cox, W. J.,	*San Francisco*	23
Coyle, J. D., Jr.,	*Sacramento*	19
Coyne, A. E.,	*Glendale*	10
Crabtree, E. H.,	*San Diego*	22
Crabtree, W. C.,	*San Diego*	22
Craft, E. D.,	*Los Angeles*	10
Crahan, M. E.,	*Los Angeles*	10
Craig, C. A.,	*Lakeport*	12
Craig, J. B.,	*Uplands*	21
Craig, L. G.,	*Pasadena*	10
Cralg, R. G.,	*San Francisco*	23
Craig, S. A.,	*Ontario*	21
Craik, C. W.,	*Venice*	10
Crane, C. C.,	*San Francisco*	23
Crane, E. H.,	*Inglewood*	10
Crane, H. W.,	*Berkeley*	1
Crane, J. J.,	*Los Angeles*	10
Crane, N. F.,	*Los Angeles*	10
Crane, W. R.,	*Los Angeles*	10
Crane, W. W.,	*Oakland*	1
Crase, H. R.,	*Los Angeles*	10
Craven, L. L.,	*Glendale*	10
Craviotto, J. V.,	*Stockton*	24
Crawford, J. W.,	*San Francisco*	23
Crawford, W. W.,	*San Diego*	22
Crease, H. G.,	*Bakersfield*	7
Cress, W. W.,	*Sacramento*	19
Crew, D. A.,	*San Luis Obispo*	25
Criley, C. H.,	*Los Angeles*	10
Crisp, N. J.,	*Benicia*	32
Crispin, E. L.,	*Los Angeles*	10
Crockett, H. C.,	*Hayward*	1
Croft, L. E.,	*Ocean Park*	10
Cronan, L. A.,	*Davis*	38
Cronemiller, R. E.,	*Exeter*	36
Crooks, S. A.,	*Loma Linda*	21
Crosby, D.,	*Oakland*	1
Cross, W. W.,	*Oakland*	1
Crossan, J. W.,	*Los Angeles*	10
Crossen, A. S.,	*Sacramento*	19
Crow, L. B.,	*San Francisco*	23
Crowe, H. E.,	*Los Angeles*	10
Crowl, V. C.,	*Huntington Park*	10
Crowley, E.,	*Santa Maria*	27
Crowley, F. L.,	*Patton*	21
Crozier, H. C.,	*Los Angeles*	10
Cruden, A. W.,	*Saticoy*	37
Cruikshank, G. H.,	*San Diego*	22
Crum, H. C.,	*Alameda*	1
Crum, R. A.,	*Oakland*	1
Crumrine, H. C.,	*Westwood*	10
Crusan, R. E.,	*Monrovia*	10
Cryst, J. H.,	*Los Angeles*	10
Cullen, B. R.,	*Long Beach*	10
Cummings, H. R.,	*Los Angeles*	10
Cummings, J. C.,	*Glendale*	10
Cummings, M. A.,	*Chico*	2
Cummings, R. A.,	*Los Angeles*	10
Cummings, R. S.,	*Los Angeles*	10
Cummins, F. A.,	*Los Angeles*	10
Cuneo, J. C.,	*San Jose*	28
Cuneo, P. J.,	*Bakersfield*	7
Cunha, F.,	*San Francisco*	23
Cunnane, P. J.,	*Los Angeles*	10
Cunnane, T. B.,	*Los Angeles*	10
Cunningham, R. L.,	*Los Angeles*	10
Cunningham, R. L.,	*Berkeley*	1
Cunningham, T. M.,	*La Mesa*	22
Cunningham, T. T.,	*Huntington P'k*	10
Cunningham, W. E.,	*Richmond*	3
Curdts, C. E.,	*Oakland*	1
Currey, H. M.,	*Santa Ana*	16
Currie, A. H.,	*Los Angeles*	10
Currlin, A. R.,	*Milpitas*	28
Curtis, C. G.,	*Brea*	16
Curtis, L. E.,	*Hetch Hetchy*	19
Cushman, G. F.,	*San Francisco*	23
Cushman, R. A.,	*Talmage*	12
Custer, C. P.,	*Patterson*	34
Custer, L. R.,	*San Francisco*	23
Cutler, O. I.,	*Loma Linda*	21
Cutter, R. K.,	*Berkeley*	1
Cutting, J. A.,	*Agnew*	28

— D —

NAME	CITY	COUNTY SOCIETY NO.
Dabney, T. G.,	*San Francisco*	1
DaCosta, A. A.,	*San Diego*	22
Dahleen, H. E.,	*San Jose*	28
Dahlgren, R. W.,	*Fresno*	4
Dail, C. W.,	*Loma Linda*	21
Dailey, W. J.,	*Oakland*	1
Daily, K.,	*Richmond*	3
Dakin, W. B.,	*Los Angeles*	10
Dale, M. B.,	*Pasadena*	10
Dallas, D. A.,	*San Francisco*	23
Dalton, M. A.,	*Santa Ana*	16
Daly, L. E.,	*Needles*	21
Dameron, J. D.,	*Stockton*	24
Daniel, W. H.,	*Los Angeles*	10
Daniels, A. C.,	*San Rafael*	11
Dannenberg, B. A.,	*Escondido*	22
Dansky, N.,	*Los Angeles*	10
Darling, H. H.,	*San Francisco*	23
Dart, A. E.,	*Oakland*	1
Dashlell, W. A.,	*Beverly Hills*	10
Dau, N. J.,	*Fresno*	4
Davenport, J. D.,	*Los Angeles*	10
Davidson, B. R.,	*Brawley*	6
David, R. A.,	*Los Angeles*	10
Davis, A. D.,	*San Francisco*	23
Davis, A. S.,	*Oakland*	1
Davis, B. L.,	*San Francisco*	23
Davis, E. A.,	*San Francisco*	23
Davis, F. J.,	*Westwood*	9
Davis, F. J., Jr.,	*Westwood*	9
Davis, H. C.,	*San Francisco*	23
Davis, H. H.,	*El Segundo*	10
Davis, H. J.,	*Sacramento*	19
Davis, H. L.,	*Huntington Park*	10
Davis, H. W.,	*San Francisco*	23
Davis, J. D.,	*Los Angeles*	10
Davis, J. P.,	*Santa Ana*	16
Davis, K. S.,	*Los Angeles*	10
Davis, S. K.,	*Santa Ana*	16
Davis, S. S.,	*Oakland*	1
Davison, C. L.,	*Los Angeles*	10
Davison, L. C.,	*Santa Ana*	16
Davison, S. T.,	*San Francisco*	23
Davitt, G. G.,	*Los Angeles*	10
Davlin, L. P.,	*Gonzales*	14
Davy, D. G.,	*Los Angeles*	23
Dawson, G. I.,	*Napa*	15
Day, E. C.,	*Laguna Beach*	16
Day, P. W.,	*Repressa*	19
Day, R. V.,	*Los Angeles*	10
Dayton, G. O.,	*Los Angeles*	10
Deacon, G.,	*Pasadena*	10
Deakin, S. M.,	*Imola*	15
Deamer, W. C.,	*New York, N. Y.*	23
Dean, J. R.,	*Los Angeles*	10
Deane, L. C.,	*San Francisco*	23
Dearing, B. F.,	*San Francisco*	23
Dearborn, R. R.,	*Madera*	3
Debenham, M. W.,	*San Francisco*	23
de Campos, P. do A. R.,	*Hanford*	8
de Carle, D. W.,	*San Francisco*	23
Decker, C. W.,	*Los Angeles*	10
Decker, R. M.,	*Pasadena*	10
Deering, W. E.,	*Hollywood*	10
Diessler, K. J.,	*San Francisco*	1
Delamere, G. S.,	*Marysville*	39
DeLancey, C. A.,	*San Rafael*	11
DeLappe, F. R.,	*Modesto*	34
della Sala, R.,	*Oakland*	1
De Long, E. W.,	*Hollywood*	10
Delprat, G. D., Jr.,	*San Francisco*	23
Delprat, J. L. P.,	*San Francisco*	23
Dement, D. E.,	*Hampden Highland, Maine*	10
Dempsey, R. B.,	*Vallejo*	32
Den Dulk, G.,	*Ripon*	24
*Denman, C. H.,	*Berkeley*	1
Dennis, H. O.,	*Beverly Hills*	10
Denton, W. L.,	*Trona*	21
DePuy, C. A.,	*Oakland*	1
Derrick, J. S.,	*Los Angeles*	10
Desch, W. D.,	*Oakland*	1
Desimone, L. O.,	*Los Angeles*	10
Desmond, M. A.,	*Santa Monica*	10
Desparois, G. B.,	*Los Angeles*	10
Desrosier, G. W.,	*Colusa*	38
Desser, A. L.,	*Los Angeles*	10
Detling, F. E.,	*Los Angeles*	10
De Vaul, C. H.,	*Oakland*	1
De Vighne, H. C.,	*Santa Barbara*	27
Devin, S. B.,	*Los Angeles*	10
Dewey, E. B.,	*Pasadena*	10
Dewey, E. T.,	*San Francisco*	23
Dewey, H. G.,	*Yosemite*	13
Dick, P. J.,	*Berkeley*	1
Dickerson, D. G.,	*Los Angeles*	10
Dickerson, H. W.,	*San Diego*	22
Dickey, C. A.,	*San Francisco*	23
Dickey, C. D., Jr.,	*Los Angeles*	10
Dickie, W. M.,	*Berkeley*	1
Dickinson, A. E.,	*Los Gatos*	28
Dickinson, C. C.,	*McCloud*	31
Dickson, A. J.,	*Glendale*	10
Dickson, E. C.,	*San Francisco*	23
Didier, F. W.,	*Wheatland*	39
Diederich, O. P.,	*Fresno*	4
Diefenbach, W. E.,	*La Jolla*	22
Diepenbrock, A. B.,	*San Francisco*	23
Diesner, H. G.,	*Sunnyvale*	27
Dieterle, K. L.,	*Los Angeles*	10
Dietrich, H.,	*Los Angeles*	10
Dietz, H. L.,	*Oakland*	1
Diggs, C. S.,	*Los Angeles*	10
Dignan, H. H.,	*San Francisco*	23
Dillingham, F. S.,	*Los Angeles*	10
Dillon, E. T.,	*Los Angeles*	10
Dillon, J. R.,	*San Francisco*	23
Dillon, V. M.,	*San Francisco*	23
Diven, G. R.,	*Los Angeles*	10
Dixon, C. D.,	*Venice*	10
Dixon, C. E.,	*Los Angeles*	10
Dixon, H. B.,	*San Francisco*	23
Doane, B. L.,	*Pasadena*	10
Doane, C. P.,	*Fresno*	4
Doane, F. L.,	*Red Bluff*	35
Doane, P. S.,	*Pasadena*	10
Dobson, L. G.,	*San Francisco*	23
Dock, G.,	*Pasadena*	10
Dock, W.,	*San Francisco*	23
Dockweiler, R. R.,	*Los Angeles*	10
Dodd, A. M.,	*Los Angeles*	10
Dodge, W.,	*Los Angeles*	10
Dolan, P. E.,	*Livermore*	1
Dole, K. L.,	*Redlands*	21
Dolley, F. S.,	*Los Angeles*	10
Domann, A. H.,	*Orange*	16
Donald, W. G.,	*Berkeley*	1
Donaldson, A. N.,	*Santa Ana*	16
Donelan, James P.,	*Los Angeles*	10
Donoher, W. D.,	*Los Angeles*	10
Donohoe, E. C.,	*Glendale*	10
Donovan, M.,	*San Francisco*	23
Dooley, J. B.,	*Compton*	10
Doran, A. V.,	*Vallejo*	32
Dorius, G. R.,	*Oakland*	1
Dormody, H. F.,	*Monterey*	14
Dormody, H. L.,	*Monterey*	14
Dorr, W. R.,	*Arlington*	18
Dostal, R. J.,	*Santa Monica*	10
Dougall, J. P.,	*Los Angeles*	10
Dougan, S.,	*San Jose*	28
Dougherty, J. A.,	*Oakland*	1
Dougherty, P. S.,	*Los Angeles*	10
Doughty, J. F.,	*Tracy*	24
Douglass, G. H.,	*Los Angeles*	10
Douglass, P.,	*San Francisco*	23
Dow, J. N.,	*Los Angeles*	10
Dowd, R. E.,	*San Bernardino*	21
Dowling, S. W.,	*Santa Cruz*	29
Downing, S. R.,	*Oakland*	1
*Downs, A. J.,	*Los Angeles*	10
Downs, L.,	*Hollywood*	10

NAME	CITY	COUNTY SOCIETY NO.
Doyle, G. F.,	*San Francisco*	23
Doyle, J. B.,	*Los Angeles*	10
Doyle, J. C.,	*Los Angeles*	10
Doyle, J. J. L.,	*Chico*	2
Doyle, O. B.,	*Fresno*	4
Dozier, D. F.,	*Sacramento*	19
Dozier, E.,	*Redding*	30
Dozier, E. G.,	*San Fernando*	10
Dozier, L.,	*Stockton*	24
Dozier, T. J.,	*Antioch*	3
Drace, C. G.,	*Ojai*	37
Dragoo, S. V.,	*Avenal*	8
Drake, D. D.,	*San Francisco*	23
Drake, J. C.,	*Kerman*	4
Drane, W. H.,	*Los Angeles*	10
Drees, L. A.,	*San Francisco*	23
Drennan, P. G.,	*Oakland*	1
Dresel, R. L.,	*San Jose*	28
Driscoll, J. A.,	*San Francisco*	23
Druckman, J. S.,	*Los Angeles*	10
Drucks, E. S.,	*Oakland*	1
Drummond, T. A.,	*Randsburg*	21
Dryden, F. M.,	*Pasadena*	10
Dryer, D. S.,	*Los Angeles*	10
Dryer, R. G.,	*Los Angeles*	10
Dryfoos, H. L.,	*San Francisco*	23
Dudley, H. W.,	*San Rafael*	11
Dufficy, G. W.,	*Sacramento*	19
Duggan, H.,	*San Francisco*	23
Dukes, C. A.,	*Oakland*	1
Dunbar, W. V.,	*San Pedro*	10
Duncan, J. A.,	*Marysville*	39
Duncan, M. V.,	*Lompoc*	27
Duncan, R. A.,	*Placentia*	16
Duncan, R. D.,	*Los Angeles*	10
Duncan, W. C.,	*Los Angeles*	10
Dundas, R. C.,	*Los Angeles*	10
Dunlevitz, M.,	*Auburn*	17
Dunklee, G. K.,	*San Luis Obispo*	25
*Dunlap, A. K.,	*Sacramento*	19
Dunlevy, G. R.,	*Los Angeles*	10
Dunlop, J.,	*Pasadena*	10
Dunn, R. D.,	*San Francisco*	23
Dunn, R. H.,	*San Francisco*	23
Dunne, N. P.,	*Oakland*	1
Dupuich, L. R.,	*Oakland*	1
Durgin, R. M.,	*Berkeley*	1
Durnin, W. G.,	*Bottineau, No. Dak.*	10
Durr, S. A.,	*San Diego*	22
Dutton, A. C.,	*San Francisco*	23
Dutton, M. L.,	*San Francisco*	23
Duvall, E. M.,	*Long Beach*	10
Dye, W. G.,	*Los Angeles*	10
Dyke, L. H.,	*Oakland*	1
Dykes, H. R.,	*Taft*	7
Dysart, B. R.,	*Pasadena*	10

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NAME	CITY	COUNTY SOCIETY NO.
Eager, B. F.,	*San Diego*	22
Eakin, M. A.,	*Fresno*	4
Earel, F.,	*Santa Ana*	16
Earl, H. D.,	*San Pedro*	10
Earle, L. M.,	*Los Angeles*	10
Early, C. E.,	*Los Angeles*	10
Earwood, E. R.,	*Los Angeles*	10
Eastman, B. R.,	*Pasadena*	10
Eastman, W. R.,	*La Jolla*	22
Easton, D. E. F.,	*San Francisco*	23
Eaton, C. D.,	*Oakland*	1
Eaton, H. D.,	*Los Angeles*	10
Eaton, J. L.,	*Berkeley*	1
Eaton, W. H.,	*Bakersfield*	27
Eaves, J.,	*Oakland*	1
Eberhardt, G.,	*Gonzales*	14
Ebert, C. E.,	*Los Angeles*	10
Ebright, G. E.,	*San Francisco*	23
Eccleston, J. O.,	*Stockton*	24
Eckerle, W. J.,	*Wilmington*	10
Eckhardt, W.,	*Los Angeles*	10
*Eddy, I. H.,	*Glendale*	10
Eder, H. L.,	*Santa Barbara*	27
Eder, L. F.,	*Santa Barbara*	27
Edgerton, A. E.,	*San Francisco*	23
Edler, W.,	*Pasadena*	10
Edmonds, F. W.,	*Oakland*	1
Edmunds, P. K.,	*Corcoran*	8
Edson, P. J.,	*Pasadena*	10
Edward, J. T.,	*Pasadena*	10
Edwards, F. A.,	*Los Angeles*	10
Edwards, H. W.,	*Los Angeles*	10
Edwards, J. C.,	*Berkeley*	1
Edwards, M. E.,	*San Francisco*	23
Edwards, W. M.,	*San Rafael*	11
Egan, A. R.,	*Elk Creek*	38
Egleston, E. F.,	*San Francisco*	23
Ehlers, E. C.,	*Loma Linda*	21
Ehlers, H.,	*Fowler*	4
Ehrke, A. A.,	*Compton*	10
Eidenmuller, W. C., Jr.,	*San Francisco*	23
Eisen, E. G.,	*Los Angeles*	10
Eiskamp, E. H.,	*Watsonville*	29
Eklund, O. E.,	*San Francisco*	23
Eldridge, S.,	*Crockett*	3
Eliaser, M., Jr.,	*San Francisco*	23
Elkins, D. L.,	*Long Beach*	10
Ellefson, O. D.,	*Hughson*	34
Ellfk, M.,	*Long Beach*	28
Elliot, A. H., Jr.,	*Santa Barbara*	27
Elliott, A. L.,	*Berkeley*	1
Elliott, H. M.,	*Los Angeles*	10
Ellis, E. D.,	*Altadena*	10
Ellis, G.,	*Berkeley*	1
Ellis, H. O.,	*Chico*	2
*Ellis, J. A.,	*Alameda*	1
Ellis, L. T.,	*Los Angeles*	10
Ellis, L. W.,	*Alhambra*	10
Ellsworth, A. B.,	*Long Beach*	10
Ellwood, P. M.,	*Oakland*	1
Eloesser, L.,	*San Francisco*	23
Emerson, C. V.,	*Los Angeles*	10
Emerson, M. L.,	*Oakland*	1
Emery, C. E.,	*San Francisco*	23
Emery, C. K.,	*Los Angeles*	10
Emge, L. A.,	*San Francisco*	23
Emmons, C. L.,	*Ontario*	21
Empey, L. W.,	*Roseville*	17
Empie, W. M.,	*San Pedro*	10
Ende, F. M.,	*Hollywood*	10
Endres, W. J.,	*Los Angeles*	10
Eneboe, J. B.,	*San Diego*	22
Engel, E. E.,	*San Bernardino*	21
Englehorn, T. D.,	*King City*	14
Engle, H. M.,	*San Francisco*	23
English, C. F.,	*Stockton*	24
English, G. G.,	*Hollywood*	10
Enloe, N. T.,	*Chico*	2
Enos, J. B.,	*Oakland*	1
Enos, M. M.,	*Oakland*	1
Epsteen, A.,	*San Francisco*	23
Epstein, H. C.,	*Los Angeles*	10
Epstein, N. N.,	*San Francisco*	23
Erkenbeck, J. W.,	*San Diego*	22
Erlanger, V. J.,	*San Diego*	22
Ernsberger, G. H.,	*Covina*	10
Escamilla, R. F.,	*San Francisco*	23
Eshman, L. A.,	*Los Angeles*	10
Eshoo, D.,	*South Pasadena*	10
Esker, G. C., Jr.,	*St. Louis, Mo.*	23
Esnard, R. P.,	*Los Angeles*	10
Esslinger, P. H.,	*San Juan Capistrano*	16
Etter, O. R.,	*Oakland*	1
Eusden, R. B.,	*Long Beach*	10
Evans, H. R.,	*Kernville*	7
Evans, J. H.,	*Highland*	21
Evans, L. M.,	*Pasadena*	10
Evans, N. G.,	*S. Pasadena*	10
Evans, R. D.,	*Los Angeles*	10
Eveleth, R. H.,	*Roseville*	17
Everingham, S.,	*Oakland*	1
Everman, C. C.,	*Larkspur*	11
Ewens, F.,	*Beverly Hills*	10
Ewer, E. N.,	*Oakland*	1
Ewer, J. N.,	*Oakland*	1
Ewing, F. E.,	*Oakland*	1
Ewing, J. P.,	*Los Angeles*	10
Exelby, P. B.,	*Los Angeles*	10
Eymundson, K. S.,	*San Francisco*	23

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NAME	CITY	COUNTY SOCIETY NO.
Faber, H. K.,	*San Francisco*	23
Fabian, J. P.,	*Chico*	2
Facey, F. D.,	*San Fernando*	10
Fagan, R. H.,	*Los Angeles*	10
Fagan, S. F.,	*Los Angeles*	10
Fagerstrom, D. P.,	*San Jose*	28
Fairchild, C. H.,	*Woodland*	38
Fairchild, F. R.,	*Woodland*	38
Fairchild, L. H.,	*Carlsbad*	22
Falconer, E. H.,	*San Francisco*	23
Falconer, F. H.,	*Los Angeles*	10
Falconer, R. A.,	*No. Hollywood*	10
Falk, C. C.,	*Eureka*	5
Falk, C. C., Jr.,	*Eureka*	5
Falk, C. L.,	*Eureka*	5
Falk, E. V.,	*Modesto*	34
Falk, H.,	*Visalia*	36
Fallas, R. E.,	*Los Angeles*	10
Fanning, J. L.,	*Sacramento*	19
Fanson, E.,	*Pasadena*	10
Faris, H. S.,	*Tucson, Ariz.*	18
Farman, G. F.,	*Los Angeles*	10
Farmer, J. L.,	*San Diego*	22
*Farmer, L. E.,	*Folsom City*	19
Farnham, R. M.,	*Glendale*	10
Farnsworth, T. K.,	*Long Beach*	10
Farr, W. H.,	*Salinas*	14
Farrage, J.,	*Blythe*	18
Farrage, J.,	*Santa Ana*	16
Farrell, J. W.,	*Los Angeles*	10
Farrell, L. W.,	*Sacramento*	19
Farrington E. D.,	*El Monte*	10
Farrow, E. J.,	*San Diego*	22
Fate, J. C.,	*Inglewood*	10
Fate, L. W.,	*Hawthorne*	10
Fate, M. W.,	*Los Angeles*	10
Fate, W. A.,	*Los Angeles*	10
Fath, A.,	*San Francisco*	23
Faulkner, J. L.,	*Red Bluff*	35
Faulkner, W. B., Jr.,	*San Francisco*	23
Fay, J.,	*San Francisco*	23
Fearn, J. R.,	*Oakland*	1
Fearon, W. M.,	*Los Angeles*	10
Feeley, M. A.,	*San Francisco*	23
Fegen, S.,	*Los Angeles*	10
*Fehlman, W. E.,	*Santa Cruz*	29
Fehrensen, G.,	*Inglewood*	10
Feinberg, H.,	*San Francisco*	23
Feingold, B. F.,	*Los Angeles*	10
Felberbaum, W.,	*Santa Paula*	37
Feldheym, J. S.,	*San Francisco*	23
Feldman, C.,	*Maywood*	10
Feldman, J. F.,	*Los Angeles*	10
Felger, L.,	*Los Angeles*	10
Fellows, A.,	*Los Angeles*	10
Fellows, F. D.,	*San Francisco*	23
Fender, F. A.,	*San Francisco*	23
Felps, H. E.,	*Riverside*	18
Felsenthal, L.,	*Los Angeles*	10
Fenton, W. W.,	*San Bernardino*	21
Ferguson, R. A.,	*Los Angeles*	10
Fernandez, M. L.,	*Pinole*	3
Fernandez, R.,	*Downey*	10
Fernish, C. A.,	*Santa Clara*	28
Ferrier, P. A.,	*Pasadena*	10
Ferry, F. C.,	*Los Angeles*	10
Fershtand, J. B.,	*San Francisco*	23
Fetter, E. M.,	*San Diego*	22
Fibush, A.,	*San Francisco*	23
Fiegel, F. X.,	*San Bernardino*	21
Field, A. M.,	*Patterson*	34
Fielder, R. L.,	*San Francisco*	23
Fielding, G. A.,	*Brentwood Heights*	10
Fields, M.,	*Los Angeles*	10
Fieseler, W. R.,	*Los Angeles*	10
Filipello, E. A.,	*San Jose*	28
Fillmore, J. R.,	*Strathmore*	36
Finan, A. P.,	*Suisun*	32
Finch, W. C.,	*Los Angeles*	10
Findlay, F. M.,	*San Diego*	22
Findlay, H. V.,	*Santa Barbara*	27
Findley, H. P.,	*El Centro*	6
Fine, I. A.,	*Los Angeles*	10
Fine, M.,	*San Francisco*	23
Fink, D. H.,	*Los Angeles*	10
Finkelberg, I. L.,	*San Bernardino*	21
Finnerty, E. J.,	*Sonoma*	33
Finsand, V.,	*San Francisco*	23
Firestone, F.,	*San Francisco*	23
Firor, M. P.,	*Los Angeles*	10
Fischer, S. S.,	*Oakland*	1
Fish, E. S.,	*Beverly Hills*	10
Fish, L. W.,	*Los Angeles*	10
Fishbaugh, E. C.,	*Los Angeles*	10
Fishbon, H. M.,	*San Francisco*	23
Fisher, A. L.,	*San Francisco*	23
Fisher, C.,	*Los Angeles*	10
Fisher, F. D.,	*Oakland*	1
Fisher, R. E.,	*Pomona*	10
Fisher, R. H.,	*Oakland*	1
Fisher, V. L.,	*Long Beach*	10
Fisher, W. L.,	*Pomona*	10
Fist, H. S.,	*Los Angeles*	10
Fitzgerald, J. J.,	*Richmond*	3
Fitzgerald, W. W.,	*Stockton*	24
Fitzgibbon, C. C.,	*Merced Falls*	13
Fitzhugh, W. M., Jr.,	*San Francisco*	23
Fitzpatrick, E. B.,	*Martinez*	3
Flamson, R. J.,	*Los Angeles*	10
Flanders, H. B.,	*Port Chicago*	3
Flatley, M.,	*Weimar*	17
Fleisher, A. J.,	*Berkeley*	1
Fleissner, C. M.,	*Santa Rosa*	33
Fleming, E. W.,	*Los Angeles*	10
Fleming, H. W.,	*San Francisco*	23
Fleming, L. P.,	*Sanger*	4
Fleming, S.,	*Eureka*	5
Flesher, R. E.,	*Gardena*	10
Fletcher, C. D.,	*San Francisco*	23
Fletcher, E. G.,	*Oakland*	1
Fletcher, H. A.,	*San Francisco*	23
Fletcher, R.,	*San Francisco*	23
Flewelling, L. M.,	*Glendale*	10
Flitcroft, L. M. I.,	*Sacramento*	19
Flood, R. G.,	*San Francisco*	23
Floreth, O. P.,	*Dixon*	32
Flower, K. C.,	*Santa Monica*	10
Fluhmann, C. F.,	*San Francisco*	23
Flynn, V. P.,	*Pasadena*	10
Fogel, E. T.,	*Los Angeles*	10
Fogg, E. S.,	*Wasco*	7
Folkenberg, A. W.,	*Los Angeles*	10
Folkins, F. H.,	*Redlands*	21
Folte, A. G.,	*San Francisco*	23
Foord, A. G.,	*Pasadena*	10
Foote, C. G.,	*San Diego*	22
Foote, F. S.,	*San Francisco*	23
Forbes, H. J.,	*Pasadena*	10
Ford, H. G.,	*Richmond*	3

NAME	CITY	COUNTY SOCIETY NO.
Ford, R. A.,	*Los Angeles*	10
Ford, T. F.,	*Ontario*	21
Foree, L.,	*Oakland*	1
Fornoff, H. S.,	*Oakland*	1
Forsythe, J. S.,	*San Bernardino*	21
Fortier, R. M.,	*Salinas*	14
Fortson, G. R.,	*Susanville*	9
Foshay, A. W.,	*Oakland*	1
Foster, A. H.,	*Brawley*	6
Foster, C. A.,	*Pacific Grove*	14
Foster, F.,	*San Francisco*	23
Foster, G. A.,	*Grass Valley*	19
Foster, H. E.,	*Berkeley*	1
Foster, J. G.,	*Los Angeles*	10
Foster, P. A.,	*Los Angeles*	10
Foster, P. D.,	*Los Angeles*	10
Fouch, F. L.,	*San Francisco*	23
Fountain, E. R.,	*Merced*	13
Fowler, C. B.,	*Oakland*	1
Fowler, D. C.,	*Mill Valley*	11
Fowler, G. W. J.,	*Santa Clara*	28
Fowler, H. L.,	*Los Angeles*	10
Fox, C. M.,	*San Diego*	22
Fox, D. S.,	*Berkeley*	1
Fox, H. W.,	*Tulare*	36
Fox, L. H.,	*Bakersfield*	7
Fox, W. F.,	*El Centro*	6
Frame, P. W.,	*Elk Grove*	19
Francis, C. H.,	*Los Angeles*	10
Francis, K. V.,	*San Mateo*	26
Francis, R. T.,	*St. Louis, Mo.*	37
Francis, R. K.,	*Inglewood*	10
Francis, R. M.,	*Pasadena*	10
Francis, V. C.,	*Long Beach*	10
Francis, W. V. C.,	*Los Angeles*	10
Francoz, M. A.,	*San Francisco*	23
Frandy, M. F.,	*Oakland*	1
Frank, J. A.,	*Pismo Beach*	25
Franklin, D. M.,	*Los Angeles*	10
Franklin, E. A.,	*Los Angeles*	10
Franklin, W. S.,	*Santa Barbara*	27
Fraser, H. E.,	*San Francisco*	23
Fraser, L. H.,	*Richmond*	3
Fraser, M. L.,	*Los Angeles*	10
Frawley, J. M.,	*Fresno*	4
Frederickson, H.,	*Eldridge*	33
Freedlander, B. L.,	*San Francisco*	23
Frees, B. M.,	*Los Angeles*	10
Fregeau, A. N.,	*San Francisco*	23
Freibrun, J. L.,	*Los Angeles*	10
Freidell, H. F.,	*Santa Barbara*	27
French, C. E.,	*San Francisco*	23
French, E. A.,	*San Luis Obispo*	25
French, J. R.,	*Los Angeles*	10
Freudenthal, L.,	*Gridley*	2
Frey, B. A.,	*Los Angeles*	10
Frey, R. G.,	*Red Bluff*	35
Frey, W. C.,	*San Francisco*	23
Freyermuth, O. G.,	*San Francisco*	23
Freytag, C. F.,	*Los Angeles*	10
Frick, D. J.,	*Los Angeles*	10
Fricke, A. A.,	*Los Angeles*	10
Friedberger, W.,	*Stockton*	24
Friedlander, R. D.,	*San Francisco*	23
Friedman, A.,	*San Francisco*	26
*Friedman, J. C.,	*Banning*	18
Friedman, L.,	*Los Angeles*	10
Friedman, M.,	*Los Angeles*	10
Friesen, H. J.,	*Glendale*	10
Frisch, A.,	*Los Angeles*	10
Fritschen, W.,	*San Francisco*	23
Frizzell, R. R.,	*Pasadena*	10
Froehlich, D. E.,	*Oakland*	1
Frohman, B. S.,	*Los Angeles*	10
Frost, E.,	*Stockton*	24
Frost, G. A.,	*Oroville*	2
Frost, K. P.,	*Los Angeles*	10
Frudenfeld, J. C.,	*Inglewood*	10
Frug, J.,	*Oakland*	1
Fry, L. C.,	*San Diego*	22
Fujikawa, Y. F.,	*Terminal Island*	10
Fulkerson, C. R.,	*Oakdale*	34
Fuller, H. L.,	*San Diego*	22
Fuller, M. B.,	*Julian*	22
Fulmer, C. C.,	*San Francisco*	23
Fung, L.,	*Sacramento*	19
Furbush, C. G.,	*Oakland*	1
Furlong, R. M.,	*San Francisco*	11
Futch, C. E.,	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Gaffney, G. F.,	*San Francisco*	23
Gafford, J. A.,	*Huntington Park*	10
Gage, A. E.,	*Los Angeles*	10
Gage, A. T.,	*Redlands*	21
Gage, C. E.,	*Conchas Dam, N. Mex.*	10
Gageby, L. H.,	*Los Angeles*	10
Gagnon, A. L.,	*San Diego*	22
Gailmard, C. R.,	*Los Angeles*	10
Galbraith, A.,	*Oakland*	1
Galbraith, G. H.,	*Long Beach*	10
Gale, W. V.,	*Los Angeles*	10
Gallagher, H. F.,	*Los Angeles*	10
Gallagher, V. J.,	*Los Angeles*	10
Gallant, A. E.,	*Los Angeles*	10
Gallant, P. A.,	*Huntington Park*	10
Gallegos, P. B.,	*Stockton*	24
Galligan, C. A.,	*Monterey*	14
Gallwey, J.,	*San Francisco*	23
Gamette, D. L.,	*Los Angeles*	10
Ganoe, C. V.,	*Los Angeles*	10
Gans, C. C.,	*Redwood City*	26
Gans, C. H.,	*Long Beach*	10
Gant, H. R.,	*Modesto*	34
Garcia, L. C.,	*San Francisco*	23
Gardenier, W. H.,	*San Francisco*	28
Gardner, C. S.,	*Oakland*	1
Gardner, F. M.,	*San Bernardino*	21
Gardner, F. W.,	*Loma Linda*	21
Gardner, H. L.,	*San Francisco*	23
Gardner, K. D.,	*San Francisco*	23
Gardner, W. E.,	*Riverside*	18
Gardner, W. M.,	*Los Angeles*	10
Garfinkle, F. E.,	*San Francisco*	23
Garland, L. H.,	*San Francisco*	23
Garner, G. W.,	*Taft*	7
Garnett, A. S.,	*San Bernardino*	21
Garrett, F. H.,	*Camarillo*	21
Garrison, B. E.,	*Riverside*	18
Garrison, E. J.,	*Blythe*	18
Garrison, J. F.,	*Inglewood*	10
Garrison, O. H.,	*Oakland*	1
Garrison, W. P.,	*Long Beach*	10
Garstang, D. B.,	*Los Angeles*	10
Garth, W. L.,	*San Diego*	22
Garvin, C. L.,	*Livingston*	13
Gaspard, F. J.,	*Los Angeles*	10
Gassman, F.,	*Los Angeles*	10
Gasteiger, E. S.,	*Los Angeles*	10
Gates, C. Y.,	*San Francisco*	23
Gates, F. K.,	*El Monte*	10
Gates, M. G.,	*Santa Monica*	10
Gates, M. J.,	*Santa Cruz*	29
Gates, R.,	*Minot, N. D.*	27
Gattuccio, B.,	*San Jose*	28
Gaulden, C. L.,	*Los Angeles*	10
Gauthier, A. E.,	*San Francisco*	23
Gay, H. M.,	*Pasadena*	10
Gay, LeR. K.,	*San Francisco*	23
Geddes, M. A.,	*Santa Ana*	16
Geen, R. S.,	*Hollister*	20
Gehrels, E.,	*San Francisco*	23
Gehrels, F.,	*San Mateo*	26
Geiger, J. C.,	*San Francisco*	23
Geisler, W. H.,	*San Jose*	28
Geistweit, W. H., Jr.,	*San Diego*	22
Geith, C. R.,	*Riverside*	18
Gelston, C. F.,	*San Francisco*	23
Gentry, H. G.,	*Redlands*	21
George, A. R.,	*Loma Linda*	21
George, J. DeW.,	*Hollywood*	10
George, J. M.,	*San Francisco*	23
George, L. H.,	*Loma Linda*	21
George, W. A.,	*Loma Linda*	21
Gerbode, F. L. A.,	*San Francisco*	23
Gericke, O. L.,	*Talmage*	12
Gerisch, H. H.,	*Los Angeles*	10
Gerlach, F. C.,	*San Jose*	28
Gerlough, R. J.,	*Menlo Park*	26
Germann, A. C.,	*Los Angeles*	10
Gernand, H. C.,	*Los Angeles*	10
Gerrard, C. C.,	*Redding*	30
Gerstle, M., Jr.,	*San Francisco*	23
Geshelin, H. I.,	*Los Angeles*	10
Getze, G. W.,	*Carlsbad*	22
Geyman, M. J.,	*Santa Barbara*	27
Ghillotti, A. E.,	*Modesto*	14
Ghormley, V. G.,	*Fresno*	4
*Ghrist, D. G.,	*Los Angeles*	10
Ghrist, D. M.,	*Glendale*	10
Ghrist, O. E.,	*Glendale*	10
Giannini, A. H.,	*Beverly Hills*	23
Giberson, A. F.,	*Watsonville*	29
Gibbons, H., III,	*San Francisco*	23
Gibbons, H. W.,	*Sacramento*	19
Gibbons, M. R.,	*San Francisco*	23
Gibbons, M. R., Jr.,	*San Francisco*	23
Gibbs, D. H.,	*Los Angeles*	10
Gibbs, R. S.,	*San Bernardino*	21
Gibbs, W. M.,	*Glendale*	10
Gibson, A. L.,	*Los Angeles*	10
Gibson, T. E.,	*San Francisco*	23
Gidley, D. S.,	*Ontario*	21
Gidoli, S. H.,	*San Francisco*	23
Gilbert, E. W.,	*Los Angeles*	10
Gilbert, J. S.,	*Los Angeles*	10
Gilbert, N.,	*Van Nuys*	10
Gilbert, Q. O.,	*Oakland*	1
Gilbert, R.,	*San Francisco*	23
Gilbert, W. H.,	*Laguna Beach*	10
Gilcreest, E. L.,	*San Francisco*	23
Giles, F. E.,	*Los Angeles*	10
Gilfillan, H. M.,	*San Francisco*	23
Gilkey, W. D.,	*Long Beach*	10
Gillespie, P. B.,	*Santa Ana*	16
Gilliatt, W. H.,	*Coalinga*	4
Gillihan, A. F.,	*San Luis Obispo*	25
Gilliland, M. L.,	*Los Angeles*	10
Gilliland, R. C.,	*Huntington Park*	10
Gillis, J. D.,	*Los Angeles*	10
Gillis, J. P.,	*Los Angeles*	10
Gilman, A. A.,	*San Francisco*	23
Gilman, P. K.,	*San Francisco*	23
Gilman, P. J., Jr.,	*San Francisco*	23
Gingold, B.,	*Los Angeles*	10
Ginsburg, H. M.,	*Fresno*	4
Ginsburg, S. S.,	*Visalia*	36
Giordano, M.,	*San Francisco*	23
Giovannetti, R. P.,	*San Francisco*	23
Girard, F. R.,	*San Francisco*	23
Girdlestone, C. W.,	*Riverside*	18
Gius, E. A.,	*San Francisco*	23
Glascock, F. L.,	*Los Angeles*	10
Glaser, M. A.,	*Los Angeles*	10
Glass, K. W.,	*Venice*	10
Glass, S. J.,	*Los Angeles*	10
Glassman, S. C.,	*Los Angeles*	10
Gleason, A. L.,	*Oakland*	1
Gleeten, S. D.,	*Monrovia*	10
Glenn, LaV. P.,	*Folsom*	19
Glenn, R. A.,	*Oakland*	1
Glenn, T. H.,	*Los Angeles*	10
Glidden, R. Y., Jr.,	*Los Angeles*	10
Gliebe, P. A.,	*San Francisco*	23
Gloor, E. E.,	*Watsonville*	29
Glyer, R. T.,	*Mountain View*	28
Gobar, F. H.,	*Fullerton*	16
Gocher, T. E. P.,	*Fairfax*	11
Goddard, W. P.,	*Mill Valley*	11
Godett, M. R.,	*Los Angeles*	10
Godshall, L. D.,	*Los Angeles*	10
Godwin, D. E.,	*Long Beach*	10
Goeckerman, W. H.,	*Los Angeles*	10
Gogol, L. J.,	*Los Angeles*	10
Goin, L. S.,	*Los Angeles*	10
Golden, J. H.,	*San Francisco*	23
Goldberg, A. T.,	*Fresno*	4
Goldberg, M. B.,	*San Francisco*	23
Goldberg, P. H.,	*Los Angeles*	10
Goldberg, S. S.,	*Los Angeles*	10
Goldberg, V.,	*Long Beach*	10
Goldman, L.,	*San Francisco*	23
Goldman, T. H.,	*Los Angeles*	10
Goldman, V. S.,	*San Francisco*	23
Goldsmith, J. E.,	*Los Angeles*	10
Goldstein, J.,	*Los Angeles*	10
Goldstein, M. M.,	*Fresno*	4
Goldwasser, M.,	*Los Angeles*	10
Golitzin, A.,	*Hollywood*	10
Gomes, J. J.,	*Oakland*	1
Gompertz, K. R.,	*Berkeley*	1
Goodall, O. P.,	*Bakersfield*	7
Goodcell, R. A.,	*Los Angeles*	10
Goodman, M.,	*Stockton*	24
Goodman, M. J.,	*Eureka*	5
Gorb, R.,	*San Francisco*	23
Gordon, G. O.,	*Long Beach*	10
Gordon, G. S.,	*Los Angeles*	10
Gordon, K. W.,	*Los Angeles*	10
Gordon, M. R.,	*San Francisco*	23
Gorrell, J. S.,	*Los Angeles*	10
Gospe, S. M.,	*San Francisco*	23
Gossard, J. E.,	*Sierra Madre*	10
Gotanda, W. I.,	*Stockton*	24
Gotfredson, H. L.,	*So. Pasadena*	10
Gottbrath, N. J.,	*Agnew*	28
Gottlieb, A. J.,	*Los Angeles*	10
Gottschalk, A.,	*San Francisco*	23
Gough, A. S.,	*El Segundo*	10
Gouguet, L. J.,	*Sacramento*	19
Gould, A. A.,	*Los Angeles*	10
Gould, N. B.,	*Modesto*	34
Gourley, I.,	*Livermore*	1
Gourse, A.,	*Sacramento*	19
Gowan, C. H.,	*Glendale*	10
Graeser, H. B.,	*Holtville*	6
Graeser, J. B.,	*Oakland*	1
Graham, H. B.,	*San Francisco*	23
Graham, H. K.,	*San Diego*	22
Graham, J. P.,	*Los Angeles*	10
Graham, R. E.,	*Oakland*	1
Graham, R. S.,	*Sacramento*	19
Granger, A. S.,	*Los Angeles*	10
Grant, B. F., Jr.,	*Hollywood*	10
Grant, J. F.,	*Long Beach*	10
Grant, R. F.,	*San Francisco*	23
Grantham, D. M.,	*Oakland*	1
Gratiot, J. H.,	*Monterey*	14
Gratiot, W. M.,	*Monterey*	14
Grau, E. C.,	*Niles*	1
Graun, R. E.,	*Los Gatos*	28
Graves, C. A.,	*Beverly Hills*	10
Graves, J. H.,	*San Francisco*	23
Graves, J. M.,	*San Francisco*	23
Graves, R. V.,	*Fullerton*	16
Gray, E.,	*Los Angeles*	10
Gray, E. E.,	*Marysville*	39
Gray, E. H.,	*Woodland*	38
Gray, G. A.,	*San Jose*	28
Gray, H.,	*San Francisco*	23
Gray, J. P.,	*San Francisco*	23
Gray, J. R.,	*Carmel*	14

NAME	CITY	COUNTY SOCIETY NO.
Gray, P. A., Jr.,	*Santa Barbara*	27
Gray, R. M.,	*Indio*	18
Gray, R. N.,	*Hartford, Conn.*	23
Graybill, M. B.,	*Escondido*	22
Grayman, H. M.,	*Dos Palos*	13
Green, A. S.,	*San Francisco*	23
Green, B., Jr.,	*Riverside*	18
Green, H. R.,	*Palo Alto*	28
Green, J.,	*Los Angeles*	10
Green, J. W.,	*Vallejo*	32
*Green, L. D.,	*San Francisco*	23
Green, M. I.,	*San Francisco*	23
Green, M. M.,	*Stockton*	24
Greenbaum, G. B.,	*Los Angeles*	10
Greenbaum, L. H.,	*Los Angeles*	10
Greene, H. H.,	*Baldwin Park*	10
Greengo, C. G.,	*Los Angeles*	10
Greenman, R. A.,	*Stockton*	24
Greenschpoon, R. R.,	*Los Angeles*	10
Greenway, H. H.,	*Los Angeles*	10
Greenwood, C. F.,	*Oakland*	1
Greenwood, E. N.,	*San Francisco*	23
Greer, E. D.,	*Oakland*	1
Gregg, F. C.,	*Calexico*	6
Gregg, H. J.,	*Calexico*	6
Gregory, C. A.,	*Sanitarium*	15
Gregory, F. S.,	*Redwood City*	26
Gregory, H. L.,	*Stockton*	24
Gregory, W. A.,	*Oakland*	1
Grey, C. A.,	*Burbank*	10
Griess, R. O.,	*Salinas*	14
Griffin, W. L.,	*Los Angeles*	10
Griffith, A. H.,	*Oakland*	1
Griggs, D. E.,	*Los Angeles*	10
Grimmer, E. M.,	*Irvington*	1
Griner, E. C.,	*Stockton*	24
Grishaw, W. H.,	*Los Angeles*	10
Groat, M. J.,	*Los Angeles*	10
Groff, S. H.,	*Los Angeles*	10
Grogan, R. E.,	*Los Angeles*	10
Gronhovd, G. O.,	*Santa Paula*	37
Groper, M. J.,	*San Francisco*	23
*Gross, H. G.,	*Eureka*	5
Grosse, A. B.,	*San Francisco*	23
Groves, R. L.,	*San Francisco*	23
Grow, W. L.,	*San Diego*	22
Gruber, F. G.,	*Santa Monica*	10
Grundy, G. M.,	*Newport Beach*	16
Guedel, A. E.,	*Los Angeles*	10
Guenther, L. P.,	*Los Angeles*	10
Guerra, A. L.,	*Alameda*	1
Guggenheim, L. K.,	*Los Angeles*	10
Guidinger, W. E.,	*San Pedro*	10
Guido, F. R.,	*Visalia*	36
Guinan, E. R.,	*Richmond*	3
Gumbiner, A. A.,	*Los Angeles*	10
Gummess, K. C.,	*Los Angeles*	10
Gummig, E. A.,	*Pasadena*	10
Gumpert, M. W.,	*Los Angeles*	10
Gunderson, H. J.,	*Beverly Hills*	10
Gundrum, F. F.,	*Sacramento*	19
Gundrum, L. K.,	*Los Angeles*	10
Gundrum, W. H.,	*Owensmouth*	10
Gundry, F. J.,	*Bakersfield*	7
Gunn, F. G.,	*Kelseyville*	15
Gunther, L.,	*Los Angeles*	10
Gurdin, M. M.,	*Los Angeles*	10
Gustafson, A. W.,	*Gustine*	13
Gustafson, R. K.,	*Pasadena*	10
Guttman, P. H.,	*Sacramento*	19

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NAME	CITY	COUNTY SOCIETY NO.
Haag, E. C.,	*Sacramento*	19
Haas, S. L.,	*San Francisco*	23
Haber, W. J.,	*San Francisco*	23
Hadden, D.,	Berkeley	1
Hadden, D. R.,	*Berkeley*	1
Hadden, M. B.,	*Berkeley*	1
Haddow, N. W. A.,	*Hollywood*	10
Hadley, C. M.,	*San Bernardino*	21
Haenszel, A. L.,	*San Bernardino*	21
Hagedorn, E. F.,	*Modesto*	34
Hager, B. H.,	*Los Angeles*	10
Hagerty, T. W.,	*Camarillo*	37
Hahn, L. W.,	*Berkeley*	1
Haig, T. R.,	*Sacramento*	19
Haight, L. M.,	*Stockton*	24
Haim, A.,	*San Francisco*	23
Haines, C. L.,	*Altadena*	10
Haines, W. H.,	*Etna*	31
Haining, R. B.,	*Glendale*	10
Hainsworth, E. L.,	*Fontana*	37
Halburg, C. T.,	*Glendale*	10
Haldeman, K. O.,	*San Francisco*	23
Hale, C. W.,	*Pomona*	10
Hale, N. G.,	*Sacramento*	19
Haley, P. S.,	*San Jose*	28
Hall, A. F., Jr.,	*Los Angeles*	10
Hall, C.,	*Oakland*	1
Hall, C.,	*Los Angeles*	10
Hall, C. C.,	*Oakland*	1
Hall, E. H.,	*Vernon*	10
Hall, E. M.,	*Los Angeles*	10
Hall, G. J.,	*Sacramento*	19
Hall, G. P.,	*San Jose*	28
Hall, G. S.,	*Los Angeles*	10
Hall, H. A.,	*Redlands*	21
Hall, H. R.,	*Orange*	16
Hall, L. H.,	*Riverside*	18
Hall, L. L.,	*Montebello*	10
Hall, R. C.,	*San Diego*	22
Hall, T. G.,	*San Francisco*	23
Halley, E. C.,	*Sanger*	4
Halloran, C. R.,	*Los Angeles*	10
Halsey, W. H.,	*San Diego*	22
Halverson, W. L.,	*Pasadena*	10
Haman, J. O.,	*San Francisco*	23
Hambleton, H. G.,	*Los Angeles*	10
Hambleton, M. P.,	*Fontana*	21
Hamer, C.,	*Glendale*	10
Hamer, R. T.,	*National City*	22
Hamilton, E. M.,	*Los Angeles*	10
Hamilton, G. V.,	*Santa Barbara*	27
Hamilton, H. P.,	*Santa Monica*	10
Hamilton, J. K., Jr.,	*Alameda*	1
Hamilton, J. R.,	*Los Angeles*	10
Hamilton, L. M.,	*Oakland*	1
Hamilton, P. L.,	*Chico*	2
Hamilton, P. M.,	*Alhambra*	10
Hamilton, R. L.,	*Marysville*	39
Hamlin, O. D.,	*Oakland*	1
Hamlin, R. E.,	*Santa Rosa*	33
Hammack, R. W.,	*Los Angeles*	10
Hammons, E. B.,	*Los Angeles*	10
Hand, D. W.,	*San Francisco*	23
Hand, F. B.,	*San Francisco*	23
Hand, H. M.,	*San Francisco*	23
Hand, L. J.,	*San Francisco*	23
Hanford, F. W.,	*Los Angeles*	10
Hankins, F. D.,	*Riverside*	18
Hankins, J. W.,	*Azusa*	10
Hanley, B. J.,	*Los Angeles*	10
Hanlon, E. R.,	*Los Angeles*	10
Hanlon, E. W.,	*San Francisco*	23
Hanlon, H. H.,	*Los Angeles*	10
Hanna, C. M.,	*McArthur*	30
Hannah, W.,	*Long Beach*	10
Hansen, A. M.,	*Los Angeles*	10
Hansen, O. J.,	*Redding*	30
Hanson, G. B.,	*Long Beach*	10
Hanson, O. H.,	*San Marino*	10
Hanson, S.,	*Stockton*	24
Hanten, J. S.,	*San Francisco*	23
Hanze, H. G.,	*Solvang*	27
Hanzlik, P. J.,	*San Francisco*	26
Happ, W. M.,	*Los Angeles*	10
Hara, H. J.,	*Los Angeles*	10
Hara, M. F.,	*Los Angeles*	10
Harada, M. A.,	*Sacramento*	19
Harbaugh, O. S.,	*San Diego*	22
Harbaugh, R. W.,	*San Francisco*	23
Hardeman, V. V.,	*San Francisco*	23
Harder, W. R.,	*Los Gatos*	28
Harding, G. F.,	*Santa Monica*	10
Harding, H. W.,	*Oakland*	1
Harding, L. W.,	*Los Angeles*	10
Harding, M. C.,	*San Diego*	22
Harding, T. E. W.,	*Los Angeles*	10
Harding, W. F.,	*Point Reyes Station*	19
Hardy, B. W.,	*Huntington Beach*	16
Hare, H. P.,	*Los Angeles*	10
Hare, R. A.,	*Santa Barbara*	27
Harkness, J. T.,	*Berkeley*	1
Harmon, E. D.,	*San Francisco*	23
Harmon, R. J. P.,	*Richmond*	3
Harmon, T. G.,	*San Francisco*	23
Harner, C. E.,	*Long Beach*	10
Harner, H. R.,	*Los Angeles*	10
Harrington, D. O.,	*San Francisco*	23
Harrington, E. R.,	*San Francisco*	23
Harrington, J. T.,	*Santa Cruz*	29
Harr, R. V.,	*Kelseyville*	33
Harris, E. L.,	*Oakland*	1
Harris, F. I.,	*San Francisco*	23
Harris, G. F.,	*Encinitas*	22
Harris, H. I.,	*Los Angeles*	10
Harris, J. B.,	*Sacramento*	19
Harris, J. M.,	*Los Angeles*	10
Harris, M. S.,	*Los Angeles*	10
Harris, M. W.,	*Ross*	11
Harris, R. C.,	*Santa Ana*	16
Harris, R. E.,	*San Francisco*	23
Harris, W. A.,	*Santa Ana*	16
Harrison, E.,	*Los Angeles*	10
Harrison, W. H.,	*San Francisco*	23
Harsh, G. F.,	*San Diego*	22
Hart, A. C.,	*Sacramento*	19
Hart, C. D.,	*San Francisco*	23
Hart, D. E.,	*Oakland*	1
Hart, M. E.,	*San Francisco*	26
Hart, V. W.,	*Yreka*	31
Hart, W. E.,	*Long Beach*	10
Hart, W. E.,	*Oakland*	1
Harter, T. H.,	*Pasadena*	10
Hartman, G. W.,	*San Francisco*	23
Hartman, H.,	*Modesto*	34
Hartman, M. M.,	*San Francisco*	23
Hartman, R. B.,	*Mill Valley*	11
Hartsough, C. W., Jr.,	*Patton*	21
Hartwell, R. W.,	*Beaumont*	18
Hartwig, L. G.,	*Los Angeles*	10
Harvey, J. E.,	*Pasadena*	10
Harvey, R. J.,	*Anaheim*	16
Harwood, C. M.,	*Santa Ana*	16
Harwood, D. A.,	*Santa Ana*	16
Hashiba, G. K.,	*Fresno*	4
Haskell, H. A.,	*Santa Rosa*	33
Haskell, P. F.,	*Artesia*	10
Hastings, H.,	*Los Angeles*	10
Hastings, S. W.,	*Monterey*	14
Hastreiter, R. F.,	*Los Angeles*	10
Hatfield, H. L.,	*Pasadena*	10
Havemann, M. S.,	*Alameda*	1
Hawes, R. E.,	*Huntington Beach*	16
Hawk, C. L.,	*Los Angeles*	10
Hawkins, C. L.,	*Taft*	7
Hawkins, D. A.,	*Los Angeles*	10
Hawkins, G. A.,	*Reedley*	4
Hawkins, G. G.,	*Madera*	4
Hawkins, H. M.,	*Taft*	7
Hawkins, J. O.,	*San Rafael*	11
Hawkins, L. P.,	*Los Angeles*	10
Haworth, M. W.,	*Sacramento*	19
Haworth, W. L.,	*Los Angeles*	10
*Hay, E. O.,	*Los Angeles*	10
Hayes, C. M.,	*Los Angeles*	10
Hayes, E. W.,	*Monrovia*	10
Hayes, J. J.,	*Berkeley*	1
Haygood, A. G.,	*Downey*	10
Hayhurst, D. E.,	*Ontario*	21
Hayhurst, J. S.,	*Redlands*	21
Haymaker, W.,	*San Francisco*	23
Haynes, F. W.,	*Los Angeles*	10
*Haynes, J. R.,	*Los Angeles*	10
Hays, M. S.,	*San Francisco*	23
Hayton, C. H.,	*Los Angeles*	10
Hazel, J. K.,	*San Francisco*	23
Hazeltine, M. E.,	*San Rafael*	11
Heald, E. S.,	*Berkeley*	1
Healey, E. F.,	*San Francisco*	23
Heard, W. R.,	*Pasadena*	10
Heavey, J. T.,	*Berkeley*	24
Hebert, A. W.,	*San Francisco*	23
Hedberg, C. C.,	*San Francisco*	23
Heddens, V. O.,	*Pasadena*	10
Hedges, L. A.,	*Richmond*	3
Heegler, F. D.,	*Napa*	15
Heffelfinger, M. A.,	*Los Angeles*	10
*Heffernan, W. T.,	*Calexico*	6
Heidenreich, H. H.,	*Los Angeles*	10
Heidenreich, W. M.,	*Arcadia*	10
Heiges, L. E.,	*Lompoc*	27
Hein, G. E.,	*San Francisco*	23
Heinatz, M. A.,	*Oakland*	1
Heinzman, W. H.,	*San Francisco*	23
Heissig, I.,	*Los Angeles*	10
Held, F.,	*Los Angeles*	21
Helsley, G. F.,	*San Francisco*	23
Helstrom, G. L.,	*Fontana*	21
Hench, J. M.,	*Stockton*	24
Henderson, A. M.,	*Sacramento*	19
Henderson, C. W.,	*Santa Barbara*	27
Henderson, E. W.,	*Alameda*	1
Henderson, H. E.,	*Santa Barbara*	27
Henderson, H. G.,	*San Francisco*	23
Henderson, J. G.,	*San Francisco*	23
Henderson, R. G.,	*Long Beach*	10
Henderson, W. R.,	*Long Beach*	10
Hendricks, F. R.,	*Ventura*	37
Hendricks, M. D.,	*Wasco*	7
Hendrickson, H. S.,	*Los Angeles*	10
Henke, G. B.,	*Ontario*	21
Hennig, L. R.,	*Willows*	38
Henning, B. H.,	*San Francisco*	23
Henninger, L. L. R.,	*Pasadena*	10
Henrich A. G.,	*Los Angeles*	10
Henriksen, E.,	*Los Angeles*	10
Henry, A. W.,	*San Leandro*	1
Henry, J. R.,	*Oakland*	1
Henry, L. L.,	*Altadena*	10
Henry, M. G.,	*Los Angeles*	10
Hensel, G. C.,	*San Francisco*	23
Hensler, H. N.,	*San Anselmo*	11
Hepplewhite, J. G.,	*Chico*	2
Heppner, G. J.,	*San Francisco*	23
Herbert, W. R.,	*San Diego*	22
Herman, B. S.,	*San Francisco*	23
Herman, H. E.,	*Corona*	18
Heron, I. C.,	*San Francisco*	23
Herrick, A. B., Jr.,	*Santa Rosa*	33
Herrick, F. L.,	*Livermore*	1
Herring, J. B.,	*San Francisco*	23
Herrington, E. L.,	*San Francisco*	23
Herscher, H. L.,	*Los Angeles*	10
Hershberg, D.,	*Los Angeles*	10
Hershberger, L.,	*Los Angeles*	10
Hershey, C. J.,	*Los Angeles*	10
Hershman, F.,	*Los Angeles*	10
Hertzog, F. C.,	*Long Beach*	10
Herzikoff, S. S.,	*Los Angeles*	10
Herzog, G. K.,	*San Francisco*	23
Hessel, V. E.,	*Los Angeles*	10
Heuler, L.,	*Fellows*	7

NAME	CITY	COUNTY SOCIETY NO.
Heuschele, W. H.,	*San Jose*	28
Hewitt, D.,	*Long Beach*	10
Hewitt, G. W.,	*Los Angeles*	10
Heylmun, H. H.,	*Long Beach*	10
Hiatt, R. S.,	*Modesto*	34
Hiatt, T. M.,	*Los Angeles*	10
Hibben, J. S.,	*Pasadena*	10
Hickey, N. G.,	*Walnut Park*	10
Hicks, A. M.,	*San Francisco*	23
Hidy, K. W.,	*Mantcca*	24
Higbee, D. R.,	*San Diego*	22
Higgs, D. W. P.,	*Chula Vista*	22
Hilgesen, J.,	*Albany*	1
Hill, A. L.,	*Los Angeles*	10
Hill, E. J.,	*Eureka*	5
Hill, E. W.,	*San Andreas*	24
Hill, H. A.,	*San Francisco*	23
Hill, H. G.,	*Redlands*	21
Hill, H. P.,	*San Francisco*	23
Hill, J. C.,	*Palm Springs*	18
Hill, L. R.,	*Long Beach*	10
Hill, M. R.,	*Los Angeles*	10
Hill, R. B.,	*Los Angeles*	10
Hill, R. C.,	*Exeter*	36
Hill, T. P.,	*Lakeport*	12
Hill, W. B.,	*Long Beach*	10
Hiller, A. W.,	*Long Beach*	10
Hilliard, C. G.,	*Redlands*	21
Hills, C. B.,	*Berkeley*	1
Hillyard, L. V.,	*Los Angeles*	10
Hillyer, L.,	*Los Banos*	13
Hilton, J. J.,	*Los Angeles*	10
Hinckley, H. A.,	*Hanford*	8
Hines, D. C.,	*Palo Alto*	28
Hines, L. W.,	*Santa Rosa*	33
Hinman, A. T.,	*San Francisco*	23
Hinman, F.,	*San Francisco*	23
Hipp, R. R.,	*Santa Barbara*	27
Hippach, R. M.,	*Los Angeles*	10
Hirsch, D. L.,	*Grass Valley*	17
Hirschfeld, M. H.,	*San Francisco*	23
Hirshfeld, S.,	*Los Angeles*	10
Hiscox, E. J.,	*Loma Linda*	21
Hitchcock, H. H.,	*Oakland*	1
Hixson, W. C., Jr.,	*Beverly Hills*	10
Hoag, C. L.,	*San Francisco*	23
Hoag, H. J.,	*San Jose*	28
Hobdy, W. C.,	*San Francisco*	23
Hodgdon, F. W., Jr.,	*Pasadena*	10
Hodges, W. A.,	*La Vina*	10
Hodgin, R. I.,	*Upland*	21
Hodgins, F. W.,	*Oakland*	1
Hodgkin, P.,	*El Centro*	6
Hoefer, A. G.,	*San Diego*	22
Hoff, C. W.,	*San Bernardino*	21
Hoffman, A. M.,	*Los Angeles*	10
Hoffman, E. F.,	*Los Angeles*	10
Hoffman, H. V.,	*San Francisco*	23
Hoffman, L. H.,	*San Francisco*	23
Hoffman, P. B.,	*Marysville*	39
Hoffman, P. E.,	*San Francisco*	23
Hoffman, R. O.,	*San Diego*	22
Hogan, M. J.,	*San Diego*	22
Hogg, R. L.,	*Saratoga*	28
Hohanshelt, A. S.,	*Olive View*	10
Hohl, E. M.,	*Los Angeles*	10
Hohnstein, F. I.,	*Napa*	1
Hoilien, M. J.,	*Eureka*	5
Hoke, P. I.,	*Los Angeles*	10
Holder, H. G.,	*San Diego*	22
Holeman, G. S.,	*Centerville*	1
Holladay, F. S.,	*Los Angeles*	10
Hollenbeck, A. E.,	*Eagle Rock*	10
Holleran, G. C.,	*Brawley*	6
Holleran, W. M.,	*Los Angeles*	10
Holley, W. W.,	*Inglewood*	10
Holliger, C. D.,	*Stockton*	24
Hollingsworth, J. B.,	*Oakland*	1
Hollingsworth, L. D.,	*Los Angeles*	10
Hollingsworth, M. W.,	*Santa Ana*	16
Hollingsworth, P.,	*French Camp*	22
Hollombe, B. S.,	*Los Angeles*	10
Holm, E.,	*Eureka*	5
Holman, E. F.,	*San Francisco*	23
Holman, W. F.,	*Los Angeles*	10
Holmer, V. C.,	*San Francisco*	23
Holmes, A. J.,	*Pasadena*	10
Holmes, F.,	*Beverly Hills*	10
Holmes, O. M.,	*San Mateo*	26
Holt, C. Z.,	*Los Angeles*	10
Holt, R. A., Jr.,	*Los Angeles*	10
Holzman, A. J.,	*Santa Barbara*	27
Holzman, R. R.,	*Los Angeles*	10
Hombach, F. J.,	*Santa Barbara*	27
Homer, R. W.,	*Ventura*	37
Homman, G. L.,	*Los Angeles*	10
Homme, O. H.,	*Los Angeles*	10
Honaker, G. T.,	*San Leandro*	1
Hoobler, H. R.,	*Oakland*	1
Hooker, G.W.,	*Lockeford*	24
Hooker, M. O.,	*Santa Barbara*	27
Hooval, J. H.,	*Ontario*	21
Hoover, E. F.,	*San Diego*	22
Hoover, J. N.,	*Long Beach*	10
Hope, R. B.,	*Los Angeles*	10
Hopkins, E. K.,	*San Francisco*	23
Hopkins, H.,	*Los Angeles*	10
Hopkins, J. J.,	*San Francisco*	23
Hopkins, J. W.,	*Glendale*	10
Hopkins, M. A.,	*Sacramento*	19
Hopkins, M. F.,	*San Jose*	28
Hopkirk, C. C.,	*Santa Monica*	10
Horn, C. E.,	*San Francisco*	23
Horner, C. D.,	*San Francisco*	23
Horner, H. E.,	*West Los Angeles*	10
Horner, W. D.,	*San Francisco*	23
Horst, W. W.,	*Wilmington*	10
Horton, F. L.,	*Pomona*	10
Horwitz, H.,	*Oakland*	1
Hosford, G. N.,	*San Francisco*	23
Hoskins, G.,	*Long Beach*	10
Hoskins, G. T.,	*Hollywood*	4
Hoskins, H. D.,	*San Diego*	22
Hosmer, C. M.,	*San Diego*	22
Hosmer, M. N.,	*San Francisco*	23
Houck, G. H.,	*Los Angeles*	10
Hough, R. C.,	*San Diego*	22
Houghton, A. D.,	*San Fernando*	10
Houloose, J.,	*Long Beach*	10
House, L. C.,	*El Centro*	6
Houseworth, A. L.,	*Los Angeles*	10
Housman, N. S.,	*San Francisco*	23
Houzvicka, O. A.,	*San Diego*	22
Hovde, A. G.,	*Hollywood*	10
Howard, B. F.,	*Sacramento*	19
Howard, C. E.,	*San Diego*	22
Howard, G. R.,	*Bell*	10
Howard, N. J.,	*San Francisco*	23
Howe, R. D.,	*Redwood City*	26
Howell, A. J.,	*Berkeley*	1
*Howell, E. H.,	*San Francisco*	23
Howitt, H. O.,	*San Rafael*	11
Howson, C. R.,	*Los Angeles*	10
Hoyt, E. B.,	*Spadra*	10
Hoyt, H. S.,	*Pacific Grove*	14
Hoyt, W. F.,	*Berkeley*	1
Hromadka, A. B.,	*Santa Monica*	10
Hromadka, J. B.,	*Santa Monica*	10
Hubbard, C. D.,	*Huntington Park*	10
Hubbert, R. H.,	*Arvin*	22
Hubert, C. I.,	*Los Angeles*	10
Huenergardt, A. G.,	*Los Angeles*	10
Huenergardt, H. A.,	*Berkeley*	1
Huff, G. D.,	*San Diego*	22
Huff, L. J.,	*Los Angeles*	10
Huffman, H. G.,	*Santa Ana*	16
Huffman, L. D.,	*Los Angeles*	10
Huggins, W. L.,	*Los Angeles*	10
Hughes, E. G.,	*Long Beach*	10
Hughes, R. E.,	*Los Angeles*	10
Hughes, S. E.,	*Los Angeles*	10
Hull, E. H.,	*San Bernardino*	21
Hull, J. F.,	*Alhambra*	10
Hull, J. P.,	*Stockton*	24
*Hull, L. C.,	*Hollister*	20
Hull, R. L.,	*Hollister*	20
Humber, J. D.,	*San Francisco*	23
Hummel, E. W.,	*San Francisco*	12
Hummelt, B. W.,	*Nevada City*	17
Humphrey, W. H.,	*Oakland*	1
Humphreys, J. M.,	*Sanger*	4
Hunnicutt, C. C.,	*Los Angeles*	10
Hunnicutt, L. G.,	*Pasadena*	10
Hunsberger, H. S.,	*San Francisco*	23
Hund, H. O.,	*San Rafael*	11
Hunt, C. E.,	*Oakland*	1
Hunt, R. A.,	*Riverdale*	4
Hunt, V. C.,	*Los Angeles*	10
Hunt, W. A.,	*Fresno*	4
Hunt, W. R.,	*Santa Barbara*	27
Hunter, P. M.,	*Pasadena*	14
Hunter, T. V.,	*Hollywood*	10
Hunter, W. E.,	*Los Angeles*	10
Hunter, W. E.,	*Los Angeles*	10
Huntley, A. C.,	*Point Arena*	12
Huntington, B. R.,	*Los Angeles*	10
Huntington, H. A.,	*Los Angeles*	10
Hurd, A. H.,	*Los Angeles*	10
Hurwitt, S. J.,	*San Francisco*	23
Hurwitz, S.,	*San Francisco*	23
Hurwitz, S. H.,	*San Francisco*	23
Husband, R. D.,	*Modesto*	34
Huston, J. M.,	*Burlingame*	26
Hutchings, R. K.,	*San Francisco*	23
Hutchinson, W. W.,	*Los Angeles*	10
Hutchison, C. W.,	*Los Angeles*	10
Hyatt, H. W.,	*Eldridge*	33
Hyde, R. D.,	*Beverly Hills*	10
Hyland, C. M.,	*Los Angeles*	10
Hyman, E.,	*Los Angeles*	10

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Ianne, C. L.,	*San Jose*	28
Iki, G. S.,	*Sacramento*	19
Illick, C. R.,	*Santa Paula*	37
Ilsley, M. L.,	*Claremont*	10
Imerman, C. P.,	*Hollywood*	10
Imerman, S. W.,	*Hollywood*	10
Imler, H. G.,	*Los Angeles*	10
Ing, C. S.,	*Stockton*	24
Ingalls, A. T.,	*Los Angeles*	10
Ingber, I. S.,	*San Francisco*	23
Ingels, A. E.,	*San Francisco*	23
Ingham, S. D.,	*Los Angeles*	10
Inghram, H. D.,	*San Bernardino*	21
Ingram, C. H.,	*Fresno*	4
Inman, J. H.,	*Bakersfield*	7
Inman, M. M.,	*Los Angeles*	10
Inman, T. G.,	*San Francisco*	23
Innis, E. C.,	*Newhall*	10
Iriki, W. K.,	*Oakland*	1
Irish, C. W.,	*Los Angeles*	10
Irvin, C. E.,	*Anaheim*	16
Irvine, A. R.,	*Los Angeles*	10
Irvine, G. S.,	*Oakland*	1
Irvine, R. S.,	*San Francisco*	23
Irvine, S. R.,	*Los Angeles*	10
Irwin, J. C.,	*Los Angeles*	10
Isaac, J. P.,	*Glendale*	10
Isnardi, M.,	*San Francisco*	23
Isoard, M. C.,	*Sacramento*	19
Ito, P. K.,	*Los Angeles*	10
Ivey, E. D.,	*Oakland*	1

—J—

Jackson, E. A.,	*Atwater*	13
Jackson, J. E.,	*Los Angeles*	10
Jackson, L. H.,	*W. Los Angeles*	10
Jacob, H. H.,	*Long Beach*	10
Jacobs, A. M.,	*San Francisco*	23
Jacobs, F. E.,	*San Diego*	22
Jacobs, J.,	*Los Angeles*	10
Jacobs, J.,	*San Francisco*	23
Jacobs, L. C.,	*San Francisco*	23
Jacobs, M. L.,	*Los Angeles*	10
Jacobs, S. N.,	*San Francisco*	23
Jacobsen, J. F.,	*San Francisco*	23
Jacobson, H. A.,	*Fresno*	4
Jacobson, H. P.,	*Los Angeles*	10
Jacobson, P. N.,	*Oakland*	1
Jacobus, L. R.,	*Berkeley*	1
Jaekle, R. F.,	*San Francisco*	23
Jamentz, S. K.,	*Los Angeles*	10
James, C. A.,	*Fresno*	4
James, C. M.,	*Beverly Hills*	10
James, C. S.,	*Los Angeles*	10
James, L.,	*Fresno*	4
James, M.,	*San Francisco*	23
James, R. J.,	*Los Angeles*	10
James, V. M.,	*Hollywood*	10
Jameson, P. V.,	*Huntington Park*	10
Jankay, L.,	*Santa Barbara*	27
Janzen, J.,	*Loma Linda*	21
Jardini, A.,	*Los Angeles*	10
Jeancon, E. C.,	*Los Angeles*	10
Jeffry, D. E.,	*Oakland*	1
Jeffs, M. D. W.,	*Los Angeles*	10
Jelinek, J. J.	*Los Angeles*	10
Jellen, J.,	*Los Angeles*	10
Jelte, S. A.,	*Oakland*	1
Jenkins, B. E.,	*Oakland*	1
Jenkins, H. L.,	*Arcata*	5
Jenkins, K. B.,	*Oakland*	1
Jenkins, R. B.,	*Los Angeles*	10
Jenney, E. R.,	*Los Angeles*	10
Jenney, W. C.,	*Vacaville*	32
Jennison, J. E.,	*San Diego*	22
Jensen, O. B.,	*Livermore*	1
Jeong, B. Y.,	*San Francisco*	23
Jesberg, S.,	*Los Angeles*	10
Jetton, J. A.,	*Fallbrook*	22
Jewel, R. T.,	*Los Angeles*	10
Jewett, R. A.,	*Los Angeles*	10
Jimerson, J. R.,	*Long Beach*	10
Johnsen, K.,	*Agnew*	28
Johnson, C. E.,	*Long Beach*	10
Johnson, C. F.,	*Oakland*	1
Johnson, C. G.,	*Long Beach*	10
Johnson, C. M.,	*San Francisco*	23
Johnson, C. R.,	*Whittier*	10
Johnson, D. D.,	*Grass Valley*	17
Johnson, E. D. L.,	*Alhambra*	10
Johnson, E. E.,	*Palo Alto*	28
Johnson, E. H.,	*Los Angeles*	10
Johnson, F. T.,	*Monrovia*	10
Johnson, G. M.,	*Los Angeles*	10
Johnson, G. S.,	*San Francisco*	23
Johnson, H. H.,	*San Francisco*	23
Johnson, H. M.,	*Pasadena*	10
Johnson, H. R.,	*Sacramento*	19
Johnson, H. S.,	*Long Beach*	10
Johnson, H. S.,	*Los Angeles*	10
Johnson, J. D.,	*Taft*	7
Johnson, J. K.,	*Culver City*	10
Johnson, L. C.,	*Salinas*	14
Johnson, M.,	*Los Angeles*	10
Johnson, M. L.,	*Oakland*	1

NAME	CITY	COUNTY SOCIETY NO.
Johnson, N. P.,	*Stockton*	24
Johnson, O. D.,	*Los Angeles*	10
Johnson, O. F.,	*Sacramento*	19
Johnson, P.,	*San Francisco*	23
Johnson, R.,	*Compton*	10
Johnson, R. H.,	*Los Angeles*	10
Johnson, R. I.,	*Westminster*	16
Johnson, R. L.,	*Corona*	18
Johnson, R. W.,	*San Fernando*	10
Johnson, S. P.,	*Los Angeles*	10
Johnson, T.,	*Porterville*	36
Johnson, W. A.,	*Antioch*	3
Johnson, W. C.,	*Pomona*	10
Johnson, W. C.,	*Salinas*	14
Johnson, W. T.,	*Alhambra*	10
Johnston, E. J.,	*South Pasadena*	10
Johnston, F. R.,	*Oakland*	1
Johnston, H. A.,	*Anaheim*	16
Johnston, J.,	*Los Angeles*	10
Johnston, S. T.,	*National City*	22
Johnston, W. H.,	*Santa Barbara*	27
Johnstone, G. A.,	*Los Angeles*	10
Johnstone, E. M.,	*Pasadena*	10
Johnstone, K. B.,	*Imola*	15
Johnstone, R. T.,	*Los Angeles*	10
Johnstone, W. A.,	*Hanford*	8
Jones, A. A.,	*Long Beach*	10
*Jones, C. B.,	*Sacramento*	19
Jones, C. P.,	*Grass Valley*	17
Jones, C. R.,	*San Diego*	22
Jones, E. F.,	*Oakland*	1
Jones, E. M.,	*Los Angeles*	10
Jones, E. W.,	*Pasadena*	10
Jones, E. W.,	*Los Angeles*	10
Jones, F. B.,	*Vallejo*	32
Jones, G. F.,	*San Francisco*	23
Jones, G. W.,	*Los Angeles*	10
Jones, H. T.,	*Los Angeles*	10
Jones, H. W.,	*Bakersfield*	7
Jones, I. H.,	*Los Angeles*	10
Jones, I. W.,	*Los Angeles*	10
Jones, J. C.,	*Los Angeles*	10
Jones, J. P.,	*Los Angeles*	10
Jones, J. R.,	*Sacramento*	19
Jones, J. W.,	*San Francisco*	23
Jones, K. P.,	*Waikoa, Maui, T. H.*	10
Jones, L. E.,	*Roseville*	17
Jones, L. L.,	*Glendale*	10
Jones, N.,	*Los Angeles*	10
Jones, N.,	*Sacramento*	19
Jones, O. C.,	*Santa Maria*	27
Jones, O. W.,	*San Anselmo*	11
Jones, O. W., Jr.,	*San Francisco*	23
Jones, R. A.,	*San Francisco*	23
Jones, R. B.,	*San Francisco*	23
Jones, S. C.,	*San Francisco*	23
Jones, W. A.,	*Riverside*	18
Jones, W. H.,	*Long Beach*	10
Jones, W. H. G.,	*Los Gatos*	28
Jones, Z. G.,	*Downey*	10
Jordan, P. A.,	*San Jose*	28
Jorgensen, S. N.,	*San Francisco*	23
Jorgenson, N.,	*Fresno*	4
Josephs, I. L.,	*Los Angeles*	10
Josephs, L.,	*Los Angeles*	10
Josephson, J. B.,	*San Jose*	28
Joyce, T. F.,	*Spadra*	10
Judd, G. E.,	*Los Angeles*	10
Judefind, T. F.,	*Loma Linda*	21
Judge, W. D.,	*Los Angeles*	10
Judson, H. A.,	*Los Angeles*	10
Juenemann, G. F.,	*Los Angeles*	10
Julien, A. E.,	*Turlock*	34
Jumblatt, A.,	*Pacific Beach*	22
Jump, K.,	*San Mateo*	26

— K —

Kaelber, A. P.,	*San Francisco*	23
Kaffesieder, L. I.,	*Los Angeles*	10
Kaftan, L. L.,	*Los Angeles*	10
Kahl, C. W.,	*Incline*	13
Kahler, A. R.,	*Sacramento*	19
Kahn, H.,	*New Orleans, La.*	27
Kahn, J.,	*Los Angeles*	10
Kahn, M. G.,	*Los Angeles*	10
Kalfus, J. L.,	*Santa Maria*	27
Kalichman, G. S.,	*Santa Monica*	10
Kanagawa, H. H.,	*Stockton*	24
Kane, L. M.,	*Los Angeles*	10
Kanner, H. M.,	*Sacramento*	19
Kaplan, H. E.,	*Stockton*	24
Kaplan, M.,	*Los Angeles*	10
Kapp, M. W.,	*San Jose*	28
Karfiol, G. J.,	*San Francisco*	23
Karo, H. L.,	*Grass Valley*	17
Karr, M.,	*Sonora*	24
Karras, R. W.,	*Dwight, Ill.*	10
Karshner, R. G.,	*Los Angeles*	10
Katz, B.,	*Los Angeles*	10
Kaufman, B.,	*San Francisco*	23
Kavanagh, M. F.,	*San Francisco*	23
Kavinoky, N. R.,	*Los Angeles*	10
Kay, G. L.,	*Redding*	30
Kay, M. M.,	*Shafter*	7
Kay, R.,	*Los Angeles*	10
Kay, W. E., Jr.,	*San Francisco*	23
Kaysen, R.,	*San Diego*	22
Kearney, F. K.,	*Hayward*	1
Kearney, W. B.,	*San Francisco*	23
Keating, V. J.,	*Los Angeles*	10
Keeler, N. S.,	*Oakland*	1
Keenan, A. S.,	*San Francisco*	23
Keeney, M. J.,	*Los Angeles*	10
Kegel, A. H.,	*Los Angeles*	10
*Kehr, E. F.,	*Pasadena*	14
Kelper, G. F.,	*Beverly Hills*	10
Keith, C. F.,	*Williams*	38
Kelker, G. D.,	*San Luis Obispo*	25
Kell, F. B.,	*San Bernardino*	21
Keller, F.,	*Los Angeles*	10
Keller, S. H.,	*Riverside*	18
Kelley, E. H.,	*San Diego*	22
Kelley, H. W.,	*Oakland*	1
Kelley, J. W.,	*Los Angeles*	10
Kellogg, E. C.,	*Los Angeles*	10
Kellogg, F.,	*Long Beach*	10
Kellogg, J. O.,	*San Diego*	22
Kelly, A. L.,	*Oceanside*	22
Kelly, T. H.,	*San Francisco*	23
Kelsey, T. W.,	*Sacramento*	19
Kelso, G. C.,	*Pittsburg*	3
Kelso, R. W.,	*Long Beach*	10
Kemp, D. H.,	*San Francisco*	23
Kemper, C. A. S.,	*Escondido*	22
Kennedy, C. R.,	*Paso Robles*	25
Kennedy, K. E.,	*Oakland*	1
Kennedy, W. J.,	*Oakland*	1
Kennell, L. A.,	*San Diego*	22
Kenney, E. W.,	*Oakland*	1
Kennicott, R. H.,	*Los Angeles*	10
Kerlan, M.,	*Beverly Hills*	10
*Kern, B. C.,	*Jackson*	19
Kerns, C. L.,	*Pittsburg*	3
Kerr, W. J.,	*San Francisco*	23
Kersten, E. H. W.,	*Anaheim*	16
Kersten, H. M.,	*Los Angeles*	10
Keser, M. D.,	*Richmond*	3
Kesling, E. F.,	*Trona*	21
Kessler, E. E.,	*Los Angeles*	10
Key, W. A.,	*San Mateo*	26
Keye, J. D.,	*Beverly Hills*	10
Keyes, H. R.,	*Los Angeles*	10
Kibbe, M. E.,	*Oakland*	1
Kibby, S. V.,	*Los Angeles*	10
Kidder, F. W. K.,	*Los Angeles*	10
Kiger, W. H.,	*Los Angeles*	10
Kilbourne, E. D.,	*Los Gatos*	28
Kilbourne, N. J.,	*Los Angeles*	10
Kilcher, C. W.,	*Sacramento*	19
Kilduff, R.,	*Oroville*	2
Kile, R. F.,	*San Francisco*	23
Kilfoy, E. J.,	*Los Angeles*	10
Kilgore, A. M.,	*Hollywood*	10
Kilgore, A. R.,	*San Francisco*	23
Kilgore, E. S.,	*San Francisco*	23
Kilgore, G. L.,	*San Diego*	22
Kimball, T. S.,	*Glendale*	10
Kimberlin, L. O.,	*San Francisco*	23
Kinard, K. W.,	*La Jolla*	22
Kindall, C. E.,	*Los Angeles*	10
Kindall, L. E.,	*Oakland*	1
Kindopp, D. M.,	*Auburn*	17
King, C. S.,	*Los Angeles*	10
King, D. E.,	*San Francisco*	23
King, E. B.,	*Arroyo Grande*	25
King, E. H.,	*Tujunga*	10
King, J. A.,	*Ojai*	37
King, J. C. E.,	*San Diego*	22
King, J. M.,	*Los Angeles*	10
King, N. C.,	*Los Angeles*	10
King, W.,	*Chico*	2
Kinkade, J. M.,	*Inglewood*	10
Kinney, L. C.,	*San Diego*	22
Kinney, M. A. J.,	*Los Angeles*	10
Kinney, P. B.,	*Pasadena*	10
Kinslow, F. A.,	*San Francisco*	23
Kinzer, E. E.,	*South Pasadena*	10
Kirchner, A. A.,	*Los Angeles*	10
Kirchner, H. J.,	*Los Angeles*	10
Kirchoff, J. J.,	*Los Angeles*	10
Kirk, A. W.,	*San Francisco*	23
Kirk, J. H.,	*Palo Alto*	28
Kirk, M. E.,	*Oakland*	1
Kirkle, O. L.,	*Napa*	15
Kirkpatrick, J. E.,	*Los Angeles*	10
Kirkpatrick, J. H.,	*Los Angeles*	10
Kirsch, R. L.,	*Pasadena*	10
Kirwin, J. J.,	*Ukiah*	12
Kiser, A. E.,	*Imola*	15
Kiskadden, W. S.,	*Los Angeles*	10
Kistinger, W. F.,	*Santa Ana*	16
Kistler, J. E.,	*San Francisco*	23
Kistler, R. H.,	*San Francisco*	23
Kitagawa, K. J.,	*San Francisco*	23
Kitsuda, F. Y.,	*Sacramento*	19
Kittridge, E. McN.,	*Los Angeles*	10
Kjaerbye, C. P. H.,	*Fresno*	4
Klabunde, E. H.,	*San Francisco*	23
Kleeman, G. E., Jr.,	*Oakland*	1
Klein, I.,	*Los Angeles*	10
Klick, J. J.,	*Sacramento*	19
Kliman, F. E.,	*Los Angeles*	10
Kling, D. H.,	*Los Angeles*	10
Klotz, N. C.,	*San Francisco*	23
Kluss, E. R.,	*Santa Barbara*	27
Klussman, H. O. G. T.,	*San Francisco*	23
Knapp, E. V.,	*San Anselmo*	11
Kneeshaw, R. S.,	*San Jose*	28
Knight, L. C.,	*San Francisco*	23
Knoll, R. F.,	*Los Angeles*	10
Knopf, B. W.,	*Brentwood*	24
Knorp, W. F.,	*Burlingame*	26
Knorr, L. R.,	*Concord*	3
Knox, C. R.,	*El Cajon*	22
Knox, L. M.,	*Carmel*	14
Knox, S. C.,	*Los Angeles*	10
Koch, P. L.,	*Sacramento*	19
Kocher, R. A.,	*Carmel*	14
Koda, K.,	*Watsonville*	29
Koebig, W. C. S.,	*Los Angeles*	10
Koefod, H. O.,	*Santa Barbara*	27
Koehler, A. E.,	*Santa Barbara*	27
Koenecke, H. J.,	*Salinas*	14
Koepke, F. H.,	*Watsonville*	29
Koerber, G. E.,	*Oakland*	1
Koetter, G. F.,	*Los Angeles*	10
Koford, H.,	*Oakland*	1
Kohlenberger, C. F. W.,	*Fullerton*	16
Kohlhase, L. H.,	*Los Angeles*	10
Kohlmoos, H. J.,	*Oakland*	1
Kohls, C. L.,	*San Francisco*	23
Kohn, F.,	*Tulare*	36
Kolb, H. J.,	*Oakland*	1
Kolda, F. O.,	*Alhambra*	10
Kolisch, J. M.,	*Los Angeles*	10
Konantz, O. F.,	*Hollywood*	10
Konigmacher, A. H.,	*Fresno*	4
Konttas, P. V.,	*Santa Rosa*	33
Koplin, H.,	*Los Angeles*	10
Kopelowitz, J. C.,	*Los Angeles*	10
Korshet, M.,	*San Francisco*	23
Kortheuer, K. H.,	*Calexico*	6
Kosky, A. A.,	*Santa Monica*	10
Kosky, A. W.,	*Santa Monica*	10
Kosterlitz, E.,	*Berkeley*	1
Kracaw, F. C.,	*Oakland*	1
Kraft, R. W.,	*Pasadena*	10
Krahullik, E. J.,	*Hollywood*	10
Kramar, L. G.,	*Fortuna*	5
Kraushaar, J. C.,	*Garden Grove*	16
Kreinman, S. G.,	*Los Angeles*	10
Kremers, E. D.,	*Pasadena*	10
Kremers, M. Y.,	*Pasadena*	10
Kress, G. H.,	*Los Angeles*	10
Kretzschmar, K. E.,	*Los Angeles*	10
Kristensen, W. A.,	*Los Angeles*	10
Kreutzmann, H. A. R.,	*San Francisco*	23
Krevitt, J. M.,	*Oildale*	7
Kroener, W. F.,	*Whittier*	10
Kroger, W. P.,	*Los Angeles*	10
Krohn, H. N.,	*Los Angeles*	10
Kroll, F. W.,	*San Francisco*	23
Krout, B. M.,	*Stockton*	24
Krueger, A. P.,	*Berkeley*	1
Krugmeier, C. E.,	*Los Angeles*	10
Krull, F.,	*Sacramento*	19
Kruse, F. H.,	*San Francisco*	23
Kruse, F. L.,	*San Francisco*	23
Kryder, G. B.,	*Glendale*	10
Kuder, W. S.,	*Oakland*	1
Kuhlmann, F. W.,	*Long Beach*	10
Kuhn, O. E.,	*Inglewood*	24
Kulaev, A. A. M.,	*San Francisco*	23
Kulchar, G. V.,	*San Francisco*	23
Kully, B. M.,	*Los Angeles*	10
Kusel, E. A.,	*Oroville*	2
Kutzmann, A. A.,	*Los Angeles*	10
Kyddson, T. W.,	*Linden*	24

— L —

Lacayo, J. R.,	*Los Angeles*	10
Lacey, J. M.,	*Los Angeles*	10
Lacey, L. E.,	*Oakland*	1
Lacey, M. J.,	*Albany*	1
Lachman, G. S.,	*San Francisco*	23
Lackner, L.,	*San Jose*	28
Lacoe, J. R.,	*Los Angeles*	10
Lafontaine, E. C.,	*San Francisco*	23
Laing, D. R.,	*Pasadena*	10
Laist, O.,	*San Francisco*	23
Lajoie, R. J.,	*Los Angeles*	10
Lake, T. O.,	*Berkeley*	1
Lakey, W. J.,	*Canoga Park*	10
Lamb, E. J.,	*Santa Barbara*	27
Lamb, L. M.,	*Oakland*	1
Lamb, W. K.,	*Berkeley*	1
Lambert, H. W.,	*Oakland*	1
Lambertson, E. R.,	*Los Angeles*	10
Lambuth, R. W.,	*Santa Barbara*	27

NAME	CITY	COUNTY SOCIETY NO.
La Mont, W.,	*Beverly Hills*	10
La Motte, L. A. J.,	*Los Angeles*	10
Lamson, M.,	*Palo Alto*	28
Lamson, R. W.,	*Los Angeles*	10
Lancaster, J. S.,	*Torrance*	10
Landegger, G. P.,	*Los Angeles*	10
Landis, C. C.,	*Chico*	2
Lando, M. E.,	*Oakland*	1
Landon, G. S.,	*San Bernardino*	21
Landrock, G. M.,	*Mill Valley*	11
Lane, C. R.,	*Santa Monica*	10
Lane, C. W.,	*Coronado*	22
Lane, E. H.,	*Los Angeles*	10
Lane, J. A.,	*Eureka*	5
Lang, J. H.,	*Fullerton*	16
Langan, A. J.,	*San Pedro*	10
Langdon, E. E.,	*Santa Monica*	10
Langdon, S. W. R.,	*Stockton*	24
Lange, H. W.,	*Bakersfield*	8
Langer, J.,	*Hilt*	31
Langley, R. W.,	*Los Angeles*	10
Langlois, L. J.,	*San Diego*	22
Langstroth, L.,	*San Francisco*	23
Lanphere, G. H.,	*Los Angeles*	10
Larkey, J.,	*Oakland*	1
Larner, T. E.,	*Marysville*	39
Larsen, A. E.,	*San Francisco*	23
Larsen, E.,	*Los Angeles*	10
Larsen, J. W.,	*Paso Robles*	25
Larsen, L. H.,	*Point Reyes*	11
Larson, A. H.,	*Los Angeles*	10
Larson, C. F.,	*Sausalito*	11
Larson, E. A.,	*Kingsburg*	4
Larson, E. E.,	*Los Angeles*	10
Lartigau, A. J.,	*San Francisco*	23
Lasswell, B. J.,	*Redwood City*	9
Laton, G. P.,	*Los Angeles*	10
Laubersheimer, G. A.,	*Los Angeles*	10
Lauder, C. H.,	*Los Angeles*	10
Lauer, C. A.,	*Long Beach*	10
Laughlin, T. J.,	*Hollywood*	10
Lavery, W. A.,	*Loyalton*	17
Lavine, B.,	*Los Angeles*	10
Lawler, P. W.,	*Victorville*	21
Lawler, W. H.,	*Salinas*	14
Lawrence, L. B.,	*Oakland*	1
Lawrence, N. B.,	*Colton*	21
Lawrence, W.,	*San Francisco*	23
Lawson, J. D.,	*Sacramento*	19
Lawson, T. C.,	*Oakland*	1
Lawyer, P. C.,	*Inglewood*	10
Layman, M. H.,	*San Francisco*	23
Lazard, E. M.,	*Los Angeles*	10
Lazelle, H. G.,	*La Jolla*	22
Leach, C. W.,	*Davis*	12
Leach, W. O.,	*Glendale*	10
Leachman, R. S.,	*Vallejo*	32
Leake, N. A.,	*Torrance*	10
Leake, W. H.,	*Los Angeles*	10
Leavenworth, E. C. S.,	*Brentwood*	24
Leavitt, A. S.,	*Los Angeles*	10
Leavitt, F. J.,	*Los Angeles*	10
Le Baron, R. O.,	*Talmage*	12
Ledford, R. M.,	*San Diego*	22
Ledyard, C. C.,	*Los Angeles*	10
Lee, D.,	*San Jose*	28
Lee, E. C.,	*San Diego*	22
Lee, F. J.,	*Santa Monica*	10
Lee, F. W.,	*Sacramento*	19
Lee, H.,	*San Jose*	28
Lee, L. H.,	*Los Angeles*	10
Lee, R. V. A.,	*Palo Alto*	28
Leef, E.,	*San Francisco*	23
Leet, N. B.,	*Oakland*	1
Leet, R. S.,	*Oakland*	1
Leete, C. M.,	*Pasadena*	10
Leffingwell, F. E.,	*Montebello*	10
Lefler, A. B.,	*Los Angeles*	10
Leftwich, O. T.,	*Oakland*	1
Legge, R. F.,	*Oakland*	1
Legge, R. T.,	*Berkeley*	1
Leggitt, R. C.,	*Glendale*	10
Leggo, R. C.,	*Crockett*	3
Leidig, L. R.,	*Santa Monica*	10
Leimbach, J. H.,	*Isleton*	18
Leiske, S. W.,	*Lodi*	24
Leland, E. B.,	*Oakland*	1
Leland, H. G.,	*Klamath*	5
Leland, S.,	*San Francisco*	23
Lemere, H. B.,	*Beverly Hills*	10
*Lenker, W. D.,	*San Bernardino*	21
Lennon, M. B.,	*San Francisco*	23
Lennon, T. J.,	*San Francisco*	23
Leon, T. D.,	*Concord*	3
Leonard, A. T.,	*San Francisco*	23
Leonard, E. M.,	*San Francisco*	23
Leonard, J. V.,	*San Francisco*	23
Leonard, W. E.,	*Los Angeles*	10
Lepper, L. E.,	*Los Angeles*	10
Lerned, M. B.,	*Pasadena*	10
Lesem, A. M.,	*San Diego*	22
Leuschner, C. E.,	*Los Angeles*	10
Levin, E. A.,	*San Francisco*	23
Levin, H. A.,	*Los Angeles*	10
Levin, H. G.,	*Westwood*	9
Levin, M. A.,	*Los Angeles*	10
Levin, W. N.,	*Avenal*	4
Levine, P.,	*Los Angeles*	10
Levitin, J.,	*Sausalito*	23
Levlton, H. I.,	*Los Angeles*	10
Levy, E. I.,	*San Diego*	23
Levy, J. J.,	*Los Angeles*	4
Levy, M. L.,	*Los Angeles*	10
Lewe, G. H.,	*Los Angeles*	10
Lewis, C. E.,	*Auburn*	17
Lewis, C. H.,	*Santa Monica*	10
Lewis, F. D.,	*Oakland*	1
Lewis, J. D.,	*Santa Barbara*	27
Lewis, K.,	*Beverly Hills*	10
Lewis, L. R.,	*Los Angeles*	10
Lewis, M. L.,	*Petaluma*	33
Lewis, N. H.,	*Hollywood*	10
Lewis, S. A.,	*Hollywood*	10
Lewis, W. M.,	*San Diego*	22
Libby, A. A.,	*Pasadena*	10
Liddell, E. B.,	*Los Angeles*	10
Lien, F. O.,	*Merced*	13
Liles, L. M.,	*Watsonville*	29
Lilienerantz, G. H.,	*Oakland*	1
Liljedahl, E. N.,	*Los Angeles*	10
Liljencrantz, E.,	*San Francisco*	23
Lilley, W. E.,	*Merced*	13
Linde, F. G.,	*San Francisco*	23
Lindberg, A. L.,	*Tucson, Ariz*	10
Lindemulder, F. G.,	*San Diego*	22
Lindenberg, F.,	*Los Angeles*	10
Lindner, H. H.,	*San Francisco*	23
Lindquist, C. A.,	*Los Angeles*	10
Lindquist, E. N.,	*Culver City*	10
Lindroth, E.,	*Long Beach*	10
Lindsay, C. V.,	*Encinitas*	22
Lindsay, H. C. L.,	*Hollywood*	10
Lindsey, J. O.,	*Santa Monica*	10
Lindsley, St. C. R.,	*Los Angeles*	10
Lineer, A. S.,	*Los Angeles*	10
Linhart, L. R.,	*Los Angeles*	10
Linn, J. L.,	*Glendale*	10
Linthicum, F. H.,	*Los Angeles*	10
Lipe, J. T.,	*La Jolla*	22
Lipkis, A.,	*Los Angeles*	10
Lipp, M. J.,	*Sacramento*	19
Lippman, M. H.,	*San Francisco*	23
Lipsett, E. M.,	*San Francisco*	23
Lipsett, P. J.,	*Oakland*	1
Lipson, B.,	*Los Angeles*	10
Lipson, I. M.,	*Visalia*	36
Lischner, H.,	*Los Angeles*	10
Lisser, H.,	*San Francisco*	23
Lissner, H. H.,	*Los Angeles*	10
Lista, L. J.,	*San Francisco*	31
Liston, E.,	*Palo Alto*	28
Litchfield, H.,	*Los Angeles*	10
Litle, E. W.,	*Los Angeles*	10
Little, R. P.,	*Santa Paula*	37
Lloyd, O. D.,	*Los Angeles*	10
Lloyd-Jones, O.,	*Los Angeles*	10
Lockwood, M. S.,	*National City*	22
Lodge, E. S.,	*Los Angeles*	10
Loe, H. D.,	*Oakland*	1
Loehr, B. E.,	*San Jose*	28
Logan, N. H.,	*Oakland*	1
Logsdon, R. O.,	*San Diego*	22
Lohmann, H. G.,	*Oakland*	1
Lohse, J. L.,	*Oakland*	1
Loizeaux, E. S.,	*San Diego*	22
Lokrantz, S. R.,	*Los Angeles*	10
Lomas, J. B.,	*Los Angeles*	10
Lomas, M. I.,	*Los Angeles*	10
Lonergan, L.,	*Loma Linda*	21
Long, F. E.,	*Los Angeles*	10
Long, H. E.,	*Berkeley*	1
Long, S. C.,	*Bakersfield*	7
Loomis, F. M.,	*Oakland*	1
Loomis, N. M.,	*Yuba City*	39
Loos, H. C.,	*Los Angeles*	10
Looser, R. V.,	*Hollywood*	10
Lopez, C. J.,	*Hollywood*	10
Lopez, E. A.,	*San Leandro*	1
Lopizich, I. J.,	*Los Angeles*	10
Lord, D. C.,	*Paradise*	2
Lordan, J. P.,	*Los Angeles*	10
Lorentz, R., Jr.,	*San Francisco*	23
Lorenz, H. E.,	*Sacramento*	19
Loring, F. W.,	*Glendale*	10
Loughlin, E. L.,	*Los Angeles*	10
Lounsberry, C. R.,	*San Diego*	22
Loutzenheiser, J. J.,	*San Francisco*	23
Love, A. A.,	*Los Angeles*	10
Love, C. A., Jr.,	*San Bernardino*	21
Love, E. C.,	*Calistoga*	15
Lovejoy, E. D.,	*Los Angeles*	10
Lovell, H. O.,	*Jackson*	19
Lovely, J. P.,	*San Jose*	28
Loven, S. M.,	*Bakersfield*	7
Loveren, G. S.,	*Santa Barbara*	27
Low, T. C.,	*Los Angeles*	10
Lowe, F. A.,	*San Francisco*	23
Lowe, W. F.,	*Jackson*	19
Lowell, G. C.,	*San Anselmo*	11
Lowman, C. L. R.,	*Los Angeles*	10
Lubin, M. L.,	*San Francisco*	23
Lucas, W.,	*Los Angeles*	10
Lucas, W. P.,	*San Francisco*	23
Lucas, W. S.,	*Richmond*	3
Lucey, D. D.,	*Los Angeles*	10
Lucia, S. P.,	*San Francisco*	23
Luckie, J. B.,	*Pasadena*	10
Luechauer, K. D.,	*Fresno*	4
Lum, D. D.,	*Alameda*	1
Lumley, C. G.,	*Huntington Park*	10
Lumsden, A. G.,	*Petaluma*	33
Lund, Le V.,	*Los Angeles*	10
Lundegaard, E. E.,	*Weimar*	17
Lundegaard, E. M.,	*Oakland*	1
Lundquist, D. T.,	*Palo Alto*	28
Lunsford, C. J.,	*Oakland*	1
Lupton, E. L.,	*Los Angeles*	10
Lurie, S. A.,	*Los Angeles*	10
Lusignan, H. R.,	*Monterey*	14
Luton, G. R.,	*Santa Barbara*	27
Lyle, A. G.,	*San Francisco*	23
Lyman, G. D.,	*San Francisco*	23
Lyman, T.,	*Sacramento*	19
Lynch, F. W.,	*San Francisco*	23
Lynch, W. P.,	*Stockton*	24
Lyster, R. W.,	*Los Angeles*	10

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*Mabee, M.,	*Santa Ana*	16
MacBeth, W. L. C.,	*El Monte*	10
MacColl, D. R.,	*Los Angeles*	10
Macdonald, C. A.,	*Barstow*	21
MacDonald, F. A.,	*Sacramento*	19
MacDonald, R. P.,	*Los Angeles*	10
Mace, L. S.,	*San Francisco*	23
Macfarlane, D. A.,	*Berkeley*	1
Mack, A. E.,	*Glendale*	10
Mack, C. W.,	*Livermore*	1
MacKay, C. H.,	*Los Angeles*	10
MacKay, E. M.,	*La Jolla*	22
Mackay, J. G.,	*Auburn*	17
Mackenzie, W. W.,	*Hollywood*	10
Mackey, J. G.,	*San Fernando*	10
MacKinnon, D. S.,	*W. Los Angeles*	10
Macklin, R. K.,	*Pasadena*	10
MacLafferty, N. C.,	*Soquel*	29
MacLean, H. G.,	*Oakland*	1
MacLean, J.,	*Los Angeles*	10
Maclennan, A. L.,	*Pasadena*	10
MacMillan, D. W.,	*Los Angeles*	10
MacMillan, H. A.,	*Long Beach*	10
Macomber, E. B.,	*Burlingame*	26
Macomber, H. W.,	*Burlingame*	26
Macpherson, D. G.,	*San Francisco*	23
Macpherson, F. L.,	*San Diego*	22
Macpherson, J. D.,	*San Diego*	22
Macpherson, W. E.,	*Los Angeles*	10
Madsen, L. J.,	*Santa Monica*	10
Magan, P. T.,	*Los Angeles*	10
Magan, W. P.,	*Covina*	10
Maghy, C. A.,	*Los Angeles*	10
Maginn, E. F.,	*Los Angeles*	10
Magoon, L. B.,	*San Jose*	28
Magrath, W. A. S.,	*Oakland*	1
Mahan, L. B.,	*San Diego*	22
Mahon, E. J.,	*San Francisco*	23
Mahoney, L. E.,	*Santa Monica*	10
Main, R. C.,	*Santa Barbara*	27
Maisler, S.,	*San Francisco*	23
Majer, R. G.,	*Los Angeles*	10
Majors, E. A.,	*Oakland*	1
Maker, R. W.,	*Norwalk*	10
Makinson, F. R.,	*Oakland*	1
Malcolmson, O. K.,	*Hynes*	10
Malis, S.,	*Los Angeles*	10
Malkin, G. M.,	*Huntington Park*	10
Malmgren, G. E.,	*Los Angeles*	10
Malone, M. C.,	*San Francisco*	23
Malone, W. M.,	*San Francisco*	23
Maloney, H. P.,	*Oakland*	1
Maloney, W. M.,	*Los Angeles*	10
Mandel, G.,	*Los Angeles*	10
Maner, G. D.,	*Los Angeles*	10
Manley, D. J.,	*Hayward*	1
Mann, A. L.,	*Los Angeles*	10
Mann, H. H.,	*Los Angeles*	10
Mann, V. L.,	*Los Angeles*	10
Mannerstedt, G. O.,	*Oakland*	1
Manning, T. P.,	*Los Angeles*	10
Manning, W. R.,	*Fillmore*	37
Manny, M. A.,	*Pasadena*	10
Mansfeldt, J. H.,	*San Francisco*	23
Manson, G.,	*Fresno*	4
Manson, R. M.,	*Hayward*	1
Mantle, V. M.,	*Los Angeles*	10
Manton, W. W.,	*Pasadena*	10
Manuel, M. M.,	*Pasadena*	10
March, H. N.,	*Grass Valley*	17
Marchildon, J. W.,	*Los Angeles*	10
Marcus, D.,	*Winterhaven*	6
Marcus, H.,	*San Francisco*	23
Marcus, S. M.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Marians, A.,	*Los Angeles*	10
Mariette, E. L.,	*Glendale*	10
Mark, A. E.,	*Los Angeles*	10
Markel, H. H.,	*San Francisco*	23
Markolf, H. F.,	*Pasadena*	10
Marks, J. H.,	*Los Angeles*	10
Marks, M.,	*Long Beach*	10
Marks, S. H.,	*Pittsburg*	3
Markthaler, E. L.,	*Santa Barbara*	27
Marlow, A. A.,	*La Jolla*	22
Marnell, F. S.,	*Stockton*	24
Maroon, J. L.,	*Santa Ana*	16
Marquis, C. E.,	*Oakland*	1
Marr, J. B.,	*Covina*	10
Marriott, J. L.,	*Alameda*	1
Marsden, C. S.,	*San Diego*	22
Marsden, S. A.,	*Santa Ana*	16
Marsh, C.,	*Sebastopol*	33
Marsh, O. G.,	*San Diego*	22
Marshall, B. M.,	*Eureka*	5
Marshall, H. K.,	*Glendale*	10
Marshall, J. M.,	*San Luis Obispo*	25
Marshall, O. C.,	*Watsonville*	29
Marston, C. B.,	*San Rafael*	11
Marston, H. E.,	*San Rafael*	11
Martin, A. T.,	*Los Angeles*	10
Martin, G. S.,	*Susanville*	9
Martin, H. H.,	*Riverside*	18
Martin, H. W.,	*Los Angeles*	10
*Martin, J. J.,	*Long Beach*	10
Martin, J. P.,	*Oakland*	1
Martin, L. A.,	*Berkeley*	1
Martin, L. E.,	*Los Angeles*	10
Martin, M. L.,	*Los Angeles*	10
Martin, P. T.,	*San Jose*	28
Martin, R. C.,	*San Francisco*	23
Martin, R. C.,	*San Bernardino*	21
Martine, A.,	*La Jolla*	22
Martins, S. M.,	*Los Angeles*	10
Martyn, G.,	*Los Angeles*	10
Marx, R.,	*Los Angeles*	10
Marxer, W. L.,	*Beverly Hills*	10
Marxmiller, H. G.,	*Los Angeles*	10
Mason, B. B.,	*Laguna Beach*	16
Mason, B. S.,	*San Jose*	28
Mason, C. A.,	*Loma Linda*	21
Mason, C. V.,	*Livermore*	1
Mason, H. E.,	*Redwood City*	26
Mason, H. M.,	*Los Angeles*	10
Mason, M. I.,	*San Jose*	28
Mason, V. R.,	*Los Angeles*	10
Massey, B. D.,	*Pasadena*	10
Masters, E. J.,	*San Francisco*	23
Masterson, J. R.,	*Berkeley*	1
Mathé, C. P.,	*San Francisco*	23
Mather, R. W.,	*Los Angeles*	10
Mathes, M. E.,	*San Francisco*	23
Mathews, S. S.,	*Los Angeles*	10
Mathewson, C.,	*Fresno*	4
Mathewson, C., Jr.,	*San Francisco*	23
Mathias, C. M.,	*Tulare*	36
Matlock, T. T.,	*Wasco*	7
Matousek, W. J.,	*Glendale*	10
Matson, J. R.,	*San Diego*	22
Mattison, C. W.,	*Los Angeles*	10
Mattison, S. J.,	*Pasadena*	10
Matzger, E.,	*San Francisco*	23
Mauer, E. F.,	*Los Angeles*	10
Maupin, J. L., Jr.,	*Fresno*	4
Mawdsley, H. L.,	*San Mateo*	26
Maxson, E. S.,	*Alhambra*	10
Maxwell, A. H.,	*Sausalito*	11
Maxwell, H. C.,	*Santa Ana*	16
Maxwell, R. E.,	*Modesto*	34
May, H. C.,	*Los Angeles*	10
May, J. A.,	*San Diego*	22
May, L. B.,	*Bakersfield*	7
Mayer, H. J.,	*Los Angeles*	10
Mayers, M. M.	*Los Angeles*	10
Mayfield, C.,	*Long Beach*	10
Mayman, E.,	*Modesto*	34
Maynard, M. T-R.,	*San Jose*	28
Mays, A. H.,	*Sausalito*	11
McAllister, H. R.,	*Taft*	7
McAllister, O. O. T.,	*Oakland*	1
McAnally, J. F.,	*Roseville*	17
McArthur, D. D.,	*Los Angeles*	10
McArthur, P. R.,	*Los Angeles*	10
McAtee, J. S.,	*Los Angeles*	10
McAuley, J.,	*Santa Ana*	16
McBride, R. W.,	*Burlingame*	26
McBurney, B. A.,	*Pomona*	10
McBurney, R. D.,	*Los Angeles*	10
McCallister, C. H.,	*Los Angeles*	10
McCann, F. E.,	*Monrovia*	10
McCarthey, A. M.,	*Los Angeles*	10
McCarthy, F. J.,	*San Francisco*	23
McCarthy, H. L.,	*Los Angeles*	10
McCarthy, J. B.,	*Carmel*	14
McCartney, O. D.,	*Glendale*	10
McCarty, R. B.,	*Riverside*	18
McCausland, A. M.,	*Los Angeles*	10
McCausland, W. S.,	*Chula Vista*	22
McChesney, G. J.,	*San Francisco*	23
McCleave, T. C.,	*Berkeley*	1
McCleave, T. C., Jr.,	*Oakland*	1
McClelland, E. S.,	*Los Angeles*	10
McClendon, S. J.,	*San Diego*	22
McClintock, G. L.,	*San Diego*	22
McClure, G.,	*Oakland*	1
McClure, J. C.,	*Lindsay*	36
McClurkin, A. A.,	*Los Angeles*	10
McColl, J. M.,	*San Diego*	22
McColl, W. F.,	*San Diego*	22
McCombs, V. J.,	*Los Angeles*	10
McConnell, J. B.,	*San Diego*	22
McConnell, O. G.,	*San Jose*	28
McCool, J. L.,	*San Francisco*	23
McCool, W. F.,	*Los Angeles*	10
McCorkle, H. J.,	*San Francisco*	23
McCoskey, G.,	*Stockton*	24
McCoy, C. A.,	*Los Angeles*	10
McCoy, E. T.,	*Los Angeles*	10
McCoy, H. H.,	*Long Beach*	10
McCracken, J. H.,	*San Pedro*	10
McCradie, R. D.,	*Oakland*	1
McCrea, F. R.,	*Long Beach*	10
McCullough, F. E.,	*Oakland*	1
McCullough, J. M.,	*Crockett*	3
McCuskey, C. F.,	*Glendale*	10
McDermott, J. C.,	*Los Angeles*	10
McDonald, A. C.,	*Huntington Park*	10
McDonald, G. H.,	*Ocean Beach*	22
McDonald, J.,	*San Francisco*	23
McDonnell, C. H.,	*Sacramento*	19
McDougall, M. W.,	*Long Beach*	10
McDowell, B. E.,	*Merced*	13
McDowell, C. A.,	*Covina*	10
McElhinney, P. P. B.,	*Long Beach*	10
McEvers, A. E.,	*Los Angeles*	10
McFarlane, A. H.,	*Mountain View*	28
McGarvey, H.,	*Atascadero*	25
McGee, R. P.,	*Los Angeles*	10
McGee, W. B.,	*San Diego*	22
McGehee, W. H.,	*Fresno*	4
McGibbon, D.,	*Los Angeles*	10
McGill, P. R.,	*Hollywood*	10
McGinnis, J. J.,	*New York*	23
McGovern, B. E.,	*San Fernando*	22
McGovney, R. B.,	*Santa Barbara*	27
McGranahan, J. H.,	*Long Beach*	10
McGrath, A. K.,	*Sonoma*	15
McGraw, L. S.,	*San Luis Obispo*	25
McGreane, F. X.,	*Calistoga*	15
McGrew, W. R.,	*Oakland*	1
McGuinness, J. E.,	*San Francisco*	23
McGuinness, J. S.,	*San Francisco*	23
McGuire, F. A.,	*Stockton*	24
McGuire, J. B.,	*Mt. Shasta*	31
McGuire, J. J.,	*San Francisco*	23
McGuire, T. E.,	*Burbank*	10
McGurk, R. T.,	*Stockton*	24
McHugh, J. A.,	*Stockton*	24
McHugh, P. H.,	*Stockton*	24
McHugh, T. R.,	*Los Angeles*	10
McIntosh, A. M.,	*Berkeley*	1
McKay, J. J., Jr.,	*San Francisco*	23
McKee, C. B.,	*Sacramento*	19
McKee, E. N.,	*Eagle Rock*	10
McKee, K. S.,	*Bakersfield*	7
McKee, W. C.,	*Los Angeles*	10
McKeehan, G. O.,	*Los Angeles*	10
McKeever, F. M.,	*Los Angeles*	10
McKellar, J. H.,	*Pasadena*	10
McKelvy, R. W.,	*Los Angeles*	10
McKenna, W. J.,	*Los Angeles*	10
McKenney, J. A.,	*Oakland*	1
McKenney, P. W.,	*Alturas*	9
McKenzie, C. R.,	*Oakland*	1
McKenzie, R. B.,	*San Francisco*	23
McKibbin, J.,	*Los Angeles*	10
McKinnon, A. A.,	*Placerville*	19
McKinnon, D. D.,	*Los Angeles*	10
McKnight, W. B.,	*Portola*	9
McLain, L. C.,	*Bakersfield*	7
McLaughlin, R. C.,	*Los Angeles*	10
McLaughlin, T. H.,	*Hollywood*	10
McLean, D.,	*Sacramento*	19
McLeish, A. H.,	*Yountville*	15
McLellan, G. H.,	*San Diego*	22
McLeod, F. L.,	*Hollywood*	10
McLeod, J. H.,	*Santa Rosa*	33
McManus, F. P.,	*Esparto*	38
McMaster, P. E.,	*Los Angeles*	10
McMeekin, H. R.,	*Lynwood*	10
McMillan, E. H.,	*Pasadena*	10
McMurdo, P. F.,	*San Francisco*	23
McMurtry, M. S.,	*Clovis*	4
McNab, T. R.,	*Los Angeles*	10
McNamara, D. H.,	*Santa Barbara*	27
McNaught, J. B.,	*San Francisco*	23
McNaught, R. C.,	*San Francisco*	23
McNeil, D.,	*Sacramento*	19
McNeil, H. G.,	*Los Angeles*	10
McNeil, W. T.,	*Stockton*	24
McNeile, L. G.,	*Los Angeles*	10
McNeile, O. M.,	*Los Angeles*	10
McNulty, A. H.,	*San Francisco*	23
McPharlin, J. H.,	*Salinas*	14
McPhee, V. C.,	*San Francisco*	23
McPheeters, E. R.,	*Modesto*	34
McPherson, M. D.,	*Santa Cruz*	29
McQuade, J.,	*San Francisco*	23
McRae, C. C.,	*San Francisco*	23
McReynolds, M. C.,	*Angwin*	15
McReynolds, R. P.,	*Los Angeles*	10
McWhirter, W. L.,	*Centerville*	1
McWhorter, P.,	*Beverly Hills*	10
Mead, C. I.,	*Bakersfield*	7
Meade, F. J.,	*Los Angeles*	10
Meads, A. M.,	*Oakland*	1
Meals, R. W.,	*Los Angeles*	10
Means, P. C.,	*Santa Barbara*	27
Meherin, J. M.,	*San Francisco*	23
Mehlin, G. B.,	*San Diego*	22
Mehrmann, H. B.,	*Oakland*	1
Meininger, W. M.,	*San Francisco*	23
Meland, O. N.,	*Los Angeles*	10
Melkonian, L.,	*Gilroy*	28
Mell, C. N.,	*Oakland*	1
Mellinger, H. V.,	*Los Angeles*	10
Mellinger, W. J.,	*Santa Barbara*	27
Melnik, M.,	*Los Angeles*	10
Mendelsohn, L.,	*Saratoga*	28
Meneray, P. A.,	*Santa Rosa*	33
Mensor, M. C.,	*San Francisco*	23
Mentzer, M. J.,	*San Francisco*	23
Mentzer, S. H.,	*San Francisco*	23
Merchant, A. K.,	*Stockton*	24
Meredith, H. H.,	*Oakland*	1
Merkle, H. J.,	*Los Angeles*	10
Mermod, C.,	*Oakland*	1
Mermod, L. E.,	*Lanai City, Lanai, T. H.*	3
Merrill, A. P.,	*San Francisco*	23
Merrill, B. E.,	*Oakland*	1
Merrill, H. G.,	*San Diego*	22
Merrill, H. P.,	*Los Angeles*	10
Merrill, J. A.,	*Monterey*	14
Merrill, R. E.,	*Burbank*	10
Merrill, W. I.,	*Campbell*	28
Merrithew, E. W.,	*Martinez*	3
Merritt, R. E.,	*San Francisco*	23
Mesirow, M. E.,	*Santa Maria*	27
Mettier, S. R.,	*San Francisco*	23
Metzner, A.,	*Los Angeles*	10
Meuser, A. H.,	*Corning*	35
Meyenberg, W. D.,	*Salinas*	14
Meyer, A. J.,	*Glendale*	10
Meyer, H.,	*San Francisco*	23
Meyers, E. L.,	*Chico*	2
Meyers, E. M.,	*Oakland*	1
Michael, L.,	*San Leandro*	1
Michael, P. P.,	*Oakland*	1
Michels, L. M.,	*San Francisco*	23
Michelson, L.,	*San Francisco*	23
Mikels, B. M.,	*Long Beach*	10
Mikels, F. M.,	*Palms*	10
Miles, R. H.,	*Alameda*	1
Miles, S. H.,	*Santa Monica*	10
Milholland, W. G.,	*Fresno*	4
Millar, G. E.,	*Sacramento*	19
Miller, A.,	*San Rafael*	11
Miller, A. H.,	*Los Angeles*	10
Miller, A. V.,	*Porterville*	36
Miller, A. W.,	*Riverside*	18
Miller, B. F.,	*Yuba-Sutter*	39
Miller, B. F.,	*Whittier*	10
Miller, C. D.,	*Glendale*	10
Miller, C. M., Jr.,	*Olive View*	10
Miller, D. G.,	*Los Angeles*	10
Miller, E. P.,	*Riverside*	18
Miller, F. F.,	*San Diego*	22
Miller, F. P.,	*Los Angeles*	10
*Miller, F. W.,	*Los Angeles*	10
Miller, G. B.,	*San Francisco*	23
Miller, H.,	*Los Angeles*	10
*Miller, H. A.,	*Alameda*	1
Miller, H. A.,	*Los Angeles*	10
Miller, H. E.,	*San Francisco*	23
Miller, H. R.,	*Chino*	21
Miller, I. S.,	*Colton*	21
Miller, J. E.,	*Los Angeles*	10
Miller, J. J., Jr.,	*San Francisco*	23
Miller, L. G.,	*Imola*	15
Miller, N.,	*Porterville*	36
Miller, N. D.,	*Los Angeles*	10
Miller, P. D.,	*Dinuba*	36
Miller, R. B.,	*Glendale*	10
Miller, R. F.,	*Los Angeles*	10
Miller, R. R.,	*Pasadena*	10
Miller, R. W.,	*Los Angeles*	10
Miller, S. J.,	*Long Beach*	10
Miller, T.,	*San Diego*	22
Miller, T. K.,	*Patton*	21
Miller, W. J.,	*Los Angeles*	10
Miller, W. McC.,	*Auburn*	17
Milliken, J. H.,	*Oakland*	1
Milliken, W. P.,	*Oakland*	1
Mills, L.,	*Los Angeles*	10
Mills, W.,	*Oakland*	1
Mills, W. W.,	*San Mateo*	26
Millspaugh, W. P.,	*Los Angeles*	10
Millzner, R. J.,	*San Francisco*	23
Milo, H. W.,	*Mountain View*	28
Milton, J. T.,	*San Diego*	22

NAME	CITY	COUNTY SOCIETY NO.
*Minaker, A. J.,	*San Francisco*	23
Minna, J. B.,	*San Diego*	22
Misch, H. B.,	*Los Angeles*	10
Missall, A. S.,	*Santa Maria*	27
Missner, F. R.,	*Oakland*	1
Mitchell, C. O.,	*Fresno*	4
Mitchell, H. H.,	*Oakland*	1
Mitchell, T. T.,	*Brawley*	6
Mitchell, W. E.,	*Berkeley*	1
Mizel, M. L.,	*San Francisco*	23
Mizener, M.,	*Southgate*	10
Miyauchi, Y.,	*Santa Maria*	27
Mock, D. C.,	*Redlands*	21
Modern, F. S.,	*Los Angeles*	10
Moes, R. J.,	*Los Angeles*	10
Moffat, W. McK.,	*Santa Barbara*	27
Moffitt, E. J.,	*Los Angeles*	10
Moffitt, H. C.,	*San Francisco*	23
*Moffitt, T. W.,	*Hollywood*	10
Mogan, R. F.,	*Los Angeles*	10
Mohs, O. K.,	*San Francisco*	23
Mohun, C. C., Jr.,	*San Francisco*	23
Mohun, M.,	*San Mateo*	26
Molgaard, J.,	*San Francisco*	26
Molitor, N.,	*San Diego*	22
Mollath, A. L.,	*Guadalupe*	27
Molony, W. R.,	*Los Angeles*	10
Monaco, S. R.,	*Los Angeles*	10
Monson, L. P.,	*San Francisco*	23
Montalvan, J.,	*Oakland*	1
Montanus, J. J.,	*Santa Ana*	16
Monteith, R. F.,	*Redwood City*	26
Montgomery, C. H.,	*Beverly Hills*	10
Montgomery, D. W.,	*San Francisco*	23
Montgomery, J. L.,	*Mandovi, Wis*	10
Montgomery, M. F.,	*San Francisco*	23
Montgomery, M. L.,	*San Francisco*	23
Montgomery, W. O.,	*San Francisco*	23
Moodie, A. R.,	*Taft*	7
Moody, A. M.,	*San Francisco*	23
Moody, E. E.,	*Los Angeles*	10
Mooney, H. S.,	*Los Angeles*	10
Mooney, T. S.,	*San Diego*	22
Moor, F. B.,	*Los Angeles*	21
Moore, A. H.,	*Los Angeles*	10
Moore, A. W.,	*Los Angeles*	10
Moore, C. B.,	*San Francisco*	23
Moore, C. E.,	*San Jose*	28
Moore, C. L.,	*Bakersfield*	7
Moore, E. C.,	*Los Angeles*	10
Moore, G.,	*Oakland*	1
Moore, G. W.,	*Los Angeles*	10
Moore, H. A.,	*Berkeley*	1
Moore, J. B.,	*Fresno*	4
Moore, J. K.,	*Los Angeles*	10
Moore, J. W.,	*Quincy*	9
Moore, L.,	*San Francisco*	23
Moore, L. S.,	*San Jose*	28
Moore, M. H.,	*Fresno*	4
Moore, N. L.,	*Santa Ana*	16
Moore, O. M.,	*Bell*	10
Moore, P. H.,	*Hollywood*	10
Moore, R.,	*Los Angeles*	10
Moore, W. G.,	*San Francisco*	23
Moore, W. H.,	*Bakersfield*	7
Moose, R. M.,	*San Bernardino*	21
Mordoff, C. E.,	*Oakland*	1
Moretti, R.,	*Los Banos*	13
Morgan, J. D., Jr.,	*Fresno*	4
Morgan, J. W.,	*San Francisco*	23
Morgan, M. D.,	*San Francisco*	23
Morley, F. J.,	*Upper Lake*	12
Morris, B. G.,	*Indio*	18
Morris, C. A.,	*Bakersfield*	7
Morris, E.,	*Auberry*	4
Morris, F. J.,	*Los Angeles*	10
Morris, G. H.,	*Santa Maria*	27
Morris, J. K., Jr.,	*Modesto*	34
Morris, K. G.,	*Petaluma*	33
Morris, L. M.,	*San Francisco*	23
Morris, M.,	*San Francisco*	23
Morris, R. L.,	*San Francisco*	23
Morrison, A. A.,	*Santa Paula*	37
Morrison, G. M.,	*San Mateo*	26
Morrison, L. F.,	*San Francisco*	23
Morrison, N. D.,	*San Mateo*	26
Morrison, R. J.,	*Santa Monica*	10
Morrison, W. A.,	*Los Angeles*	10
Morrissey, E. J.,	*San Francisco*	23
Morrow, A.,	*Richmond*	3
Morrow, H.,	*San Francisco*	23
Morse, C. O.,	*Redwood City*	26
Morse, D. L.,	*Gilroy*	28
Morse, H. A.,	*Oakland*	1
Mortensen, E. S.,	*Santa Monica*	10
Mortensen, J. P.,	*Los Angeles*	10
Mortensen, W. L.,	*Culver City*	10
Mortensen, W. S.,	*Santa Monica*	10
Morton, A. W.,	*San Francisco*	23
Morton, D. G.,	*San Francisco*	23
Morton, L. B.,	*Los Angeles*	10
Mosby, G.,	*Oakland*	1
Mosher, W. F.,	*Ventura*	37
Mote, C. D.,	*San Francisco*	23
Motley, E. G.,	*Santa Ana*	16
Mott, E. L.,	*Fresno*	4
Mottram, L. D.,	*Modesto*	34
Moulton, D. H.,	*Chico*	2
Moulton, R. R.,	*San Mateo*	26
*Mountford, G. T.,	*Coalinga*	4
Mourer, L. A.,	*Los Angeles*	10
Movitt, S. I.,	*Los Angeles*	10
Movius, C. McK.,	*Los Angeles*	10
Movius, H. J.,	*Los Angeles*	10
Moyle, C. A.,	*Merced*	13
Muckleston, H. S.,	*Los Angeles*	10
Mudd, J. L.,	*Merced*	13
Mudd, S. G.,	*San Marino*	10
Mueller, R. R.,	*Los Angeles*	10
Mugford, I. K.,	*Sacramento*	19
Mugler, F. R.,	*San Luis Obispo*	25
Muhl, A. M.,	*San Diego*	22
Muir, J. C.,	*San Jose*	28
Mulder, E. I.,	*Compton*	10
Mulfinger, C. L.,	*Los Angeles*	10
Mullaly, E. F.,	*Vallejo*	32
Mullen, E. W.,	*Agnew*	28
Mullen, J. L.,	*Sacramento*	19
Mullen, T. F.,	*San Francisco*	23
Mulligan, H. R.,	*Hollywood*	10
Mulvehill, W.,	*Los Angeles*	10
Munch, P. F.,	*Santa Barbara*	27
Mundall, B. P.,	*Glendale*	10
Munter, E. J.,	*San Francisco*	23
Murakami, K.,	*Salinas*	14
Muramoto, J.,	*Sacramento*	19
Murphy, J. B.,	*San Mateo*	26
Murphy, J. E.,	*Sacramento*	19
Murphy, M. J.,	*Redding*	30
Murphy, P. J.,	*Los Angeles*	10
Murphy, W. H.,	*San Mateo*	26
Murray, D. H.,	*Napa*	15
Murray, S.,	*Los Angeles*	10
Murrieta, A. J.,	*Los Angeles*	10
Musante, A. S.,	*San Francisco*	23
Musselman, W. H.,	*South San Francisco*	26
Musser, L. P.,	*Oakland*	1
Myers, C.,	*Los Angeles*	10
Myers, G. E.,	*Los Angeles*	10
Myers, L.,	*San Diego*	22
Myers, O. R.,	*Eureka*	5
Myers, T. C.,	*Los Angeles*	10

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Nador, G.,	*Los Angeles*	10
Naeckel, H. W.,	*Riverside*	18
Naffziger, H. C.,	*San Francisco*	23
Nagel, G. W.,	*San Francisco*	23
Nagelman, C. B.,	*Santa Barbara*	27
Nakano, Y.,	*Gaudalupe*	27
Napheys, W. D.,	*No. Hollywood*	10
Nass, F. C.,	*San Francisco*	23
Nasser, G. E.,	*San Francisco*	23
Nathanson, M. H.,	*Los Angeles*	10
Natzler, A.,	*Los Angeles*	10
Naughton, J. P.,	*Los Angeles*	10
Neal, J. R.,	*Los Angeles*	10
Neff, F. E.,	*Compton*	10
Negley, J. C.,	*Los Angeles*	10
Neighbor, J. W.,	*Arrowhead Springs*	21
Neil, J. M.,	*Oakland*	1
Nelson, A. N.,	*Los Angeles*	10
Nelson, C. E.,	*National City*	22
Nelson, C. F.,	*Los Angeles*	10
Nelson, C. H.,	*Los Angeles*	10
Nelson, C. R.,	*Oakland*	1
Nelson, C. V.,	*Los Angeles*	10
Nelson, E. A.,	*Los Angeles*	10
Nelson, E. S.,	*Los Angeles*	10
Nelson, F. H.,	*Los Angeles*	10
Nelson, H. C.,	*Santa Ana*	16
Nelson, H. M.,	*Barstow*	21
Nelson, J. E.,	*Lodi*	24
Nelson, L. G.,	*Long Beach*	10
Nelson, R. C.,	*Beverly Hills*	10
Nelson, R. F.,	*Oakland*	1
Nerad, A. H.,	*Wilmington*	10
Nesburn, H. R.,	*Hollywood*	10
Nesche, G. E.,	*Oakland*	1
Neslund, H. C.,	*Anaheim*	16
Nethercut, R. A.,	*San Francisco*	23
Netzley, R. E.,	*Pasadena*	10
Neubert, A. D.,	*Redlands*	21
Neufeld, H. D.,	*Concord*	3
Neumann, E. V.,	*Hollywood*	10
Neville, J. E.,	*Glendale*	10
Nevin, J. L.,	*San Bernardino*	21
Nevius, F. P.,	*Antioch*	3
Nevius, J. W.,	*Los Angeles*	10
Newbarr, F. D.,	*Los Angeles*	10
Newbecker, C. G.,	*Hanford*	8
Newcomb, A. T.,	*Pasadena*	10
Newel, C. D.,	*Fresno*	4
Newell, E.,	*San Jose*	28
Newell, R. R.,	*San Francisco*	23
Newkirk, H. D.,	*Anaheim*	16
Newman, A.,	*San Francisco*	23
Newman, H. W.,	*San Francisco*	23
Newman, L.,	*San Francisco*	23
Newman, M. H.,	*Los Angeles*	10
Newman, R. W.,	*Suisun*	32
Newman, W. H.,	*San Diego*	22
Newman, W. W.,	*San Francisco*	23
*Newmark, P.,	*Los Angeles*	10
Newson, H. E.,	*San Francisco*	23
Newton, A. H.,	*Yreka*	31
Newton, E. B.,	*Oakland*	1
Newton, H. D.,	*San Diego*	22
Newton, W. C.,	*San Diego*	22
Nicholas, C. Z.,	*Santa Barbara*	27
Nichols, F. C.,	*Santa Monica*	10
Nichols, J. N.,	*Los Angeles*	10
Nichols, R. C.,	*Ontario*	21
Nichols, R. E.,	*Woodland*	38
Nichols, W. E.,	*Pasadena*	10
Nicholson, J.,	*Los Angeles*	10
Nicholson, J. McG.,	*Bakersfield*	7
Nicholson, J. W.,	*Porterville*	36
Nicholson, R. M.,	*Los Angeles*	10
Nicola, T.,	*Alhambra*	10
Nider, G. K.,	*Fresno*	4
Niebel, H. L.,	*Palo Alto*	28
Niebergall, H. A.,	*Los Angeles*	10
Nielsen, H. W.,	*Fowler*	4
Nielsen, J. C. E.,	*San Diego*	22
Nielsen, J. M.,	*Los Angeles*	10
Nielson, K. A.,	*Oakland*	1
Nielson, L. R.,	*Fresno*	4
Niemand, F. G.,	*San Francisco*	23
Nies, A.,	*Orange*	16
Nies, C. A.,	*Los Angeles*	10
Nilsson, J. P.,	*Long Beach*	10
Nippert, E. F.,	*Los Angeles*	10
Nisbet, T. W.,	*Pasadena*	10
Nittler, A. N.,	*Santa Cruz*	29
Nixon, A. C.,	*Hollywood*	10
Nixon, N. K.,	*Los Angeles*	10
Noall, E. T.,	*Santa Rosa*	33
Noble, B. E.,	*Los Angeles*	10
Noble, C. A., Jr.,	*San Francisco*	23
Noble, T. E.,	*Long Beach*	10
Noetling, P. R.,	*Angels Camp*	24
Nolan, O. F.,	*San Francisco*	23
Nolan, T. J.,	*Pacific Grove*	23
Noland, C. A.,	*Long Beach*	10
Norman, G. F.,	*Eureka*	5
Norman, J. G.,	*San Pedro*	10
Norris, C. E.,	*Eureka*	5
Norris, W. J.,	*Los Angeles*	10
Northrop, R. S.,	*Napa*	15
Northway, W. H.,	*Stanford Univ*	28
Norton, F. L.,	*Los Angeles*	10
Norwood, G. E.,	*Covina*	10
Novotny, M. F.,	*Burlingame*	26
Novy, F. G.,	*Oakland*	1
Noyes, F. Le G.,	*Los Angeles*	10
Nuttall, J. P.,	*Santa Monica*	10
Nutting, F. J.,	*Santa Monica*	10
Nutting, R. J.,	*Oakland*	1
Nuyens, L. C.,	*San Francisco*	23
Nuzum, F. R.,	*Santa Barbara*	27

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Oakleaf, D. C.,	*Cloverdale*	33
O'Brien, G.,	*Sacramento*	19
O'Brien, H. J.,	*Los Angeles*	10
O'Brien, J. J.,	*Los Angeles*	10
O'Brien, J. W.,	*Sacramento*	19
O'Connell, T. S.,	*San Diego*	22
O'Connor, G. B.,	*San Francisco*	23
O'Connor, J. H.,	*San Francisco*	23
O'Connor, R. E.,	*Los Angeles*	10
O'Connor, R. P.,	*Oakland*	1
*O'Connor, T. C., Jr.,	*Lodi*	24
O'Connor, T. H.,	*San Francisco*	23
O'Donnell, F. J.,	*Stockton*	24
O'Donnell, J. M.,	*Hollister*	20
Oechsli, W. R.,	*Olive View*	10
Oftedal, S.,	*Burbank*	10
O'Grady, W. E.,	*San Francisco*	23
Ohannesian, F.,	*Sacramento*	19
Ohanneson, J.,	*Alameda*	1
O'Hara, F. P.,	*San Diego*	22
O'Hara, J. J.,	*San Diego*	22
Ohnemuller, C. E.,	*Los Angeles*	10
Okami, S.,	*Terminal Island*	10
Okonogi, B.,	*Fresno*	4
Oleh, I. Y.,	*Los Angeles*	10
Oldenbourg, L. A.,	*Berkeley*	1
Olberg, F. H.,	*Redding*	30
Olds, W. H.,	*Los Angeles*	10
Oliver, A.,	*Imola*	15
Oliver, H. R.,	*San Francisco*	23
Oliver, J. V.,	*Palm Springs*	18
Oliver, W. A.,	*San Francisco*	23
Olmsted, R. C.,	*Pasadena*	10

NAME	CITY	COUNTY SOCIETY NO.
Olney, M. B.,	*San Francisco*	23
Olsen, A. Y.,	*Los Angeles*	10
Olsen, C. W.,	*Los Angeles*	10
Olsen, D. M. R.,	*Berkeley*	1
Olsen, E. R.,	*San Francisco*	23
Olsen, G. W.,	*Fresno*	4
Olsen, S.,	*San Francisco*	23
Olsen, W. L.,	*San Francisco*	23
Olsen, X.,	*San Bernardino*	21
Olson, G. M.,	*Los Angeles*	10
Olson, G. W.,	*Fullerton*	16
Omelvena, J. G.,	*San Diego*	22
O'Neil, A. A.,	*San Francisco*	23
O'Neil, F. H.,	*Eureka*	5
O'Neill, B. J., Jr.,	*San Diego*	22
O'Neill, J. N.,	*Los Angeles*	10
O'Neill, T. J.,	*Los Angeles*	10
Onesti, S. J.,	*San Francisco*	23
Oppenheimer, L. I.,	*Oakland*	1
Orcutt, A. H.,	*Oakland*	1
Orella, F. R.,	*San Francisco*	23
Ormsby, E. A.,	*Centerville*	1
Orr, J.,	*Oakland*	1
Osborn, H. B.,	*Fillmore*	37
Osborne, R. H.,	*Los Angeles*	10
Osburn, J. N. N.,	*Los Angeles*	10
Ostroff, R. A.,	*San Francisco*	23
Otis, E. F.,	*Brea*	16
*Otis, M. R.,	*Los Angeles*	10
Otis, N. M.,	*Santa Monica*	10
Ottinger, M. R.,	*San Francisco*	23
Otto, F. W.,	*Los Angeles*	10
Oviedo, G. F.,	*San Francisco*	23
Owen, C. C.,	*San Bernardino*	21
Owen, C. S.,	*National City*	22
Owen, E. D.,	*San Francisco*	23
Owen, G. R.,	*Los Angeles*	10
Owens, R. L.,	*Lodi*	24
Owens, W. R.,	*Glendale*	10
Oyler, J. D.,	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Paap, G. F.,	*Long Beach*	10
Pace, P. T.,	*San Jose*	28
Packard, L. A.,	*Bakersfield*	7
Padden, E. H.,	*Alameda*	1
Padgett, V. W.,	*Alleghany*	17
Paez, J.,	*San Diego*	22
Page, B. H.,	*San Mateo*	26
Page, C. W.,	*Berkeley*	1
Page, W. E.,	*Oakland*	1
Pahl, P. C. H.,	*Los Angeles*	10
Paige, G. A.,	*Anaheim*	16
Paine, N. C.,	*Glendale*	10
Palamountain, W. B.,	*Oakland*	1
Pallais, A.,	*Los Angeles*	10
Pallesen, V. W.,	*Walnut Grove*	19
Pallette, E. C.,	*Los Angeles*	10
Pallette, E. M.,	*Los Angeles*	10
Palmateer, R. H.,	*Oceanside*	22
Palmer, B. M.,	*Oakland*	1
Palmer, C. B.,	*Lagunitas*	23
Palmer, E. O.,	*Hollywood*	10
Palmer, R. S.,	*Pomona*	10
Palmer, W. B.,	*Long Beach*	10
Palomeque, E. J.,	*Tampico Tampas, Mexico*	22
Paretzky, M.,	*Los Angeles*	10
Parizek, F. J.,	*Los Angeles*	10
Park, D. B.,	*Vallejo*	32
Parker, A. S.,	*Merced*	13
Parker, C. H.,	*Pasadena*	10
Parker, G.,	*Salinas*	14
Parker, H. R.,	*Oakland*	1
Parker, J. A.,	*Merced*	13
Parker, J. A.,	*Los Angeles*	10
Parker, J. L.,	*Brawley*	6
Parker, J. T.,	*Oakland*	1
Parker, L. O.,	*San Francisco*	23
Parker, T. A.,	*La Jolla*	22
Parker, W. B.,	*Los Angeles*	10
Parkin, V.,	*Los Angeles*	10
Parkinson, R. H.,	*San Francisco*	23
Parkinson, S. N.,	*Oakland*	1
Parkinson, S. R.,	*Marysville*	39
Parkinson, W. B.,	*Porterville*	36
Parks, B. K.,	*Long Beach*	10
Parks, F. R.,	*Los Angeles*	10
Parks, K. G.,	*Anaheim*	16
Parks, R. V.,	*Los Angeles*	10
Parowski, S. A.,	*San Diego*	22
Parrish, C. R.,	*Los Angeles*	10
Parrish, G.,	*Los Angeles*	10
Parrott, J. C.,	*San Francisco*	23
Parsons, H. H.,	*Barksdale Field, La.*	21
Parsons, S. R.,	*Santa Barbara*	27
Partch, W. T.,	*Oakland*	1
Pasette, S. E.,	*Los Angeles*	10
Pate, W. H.,	*Alturas*	9
Patek, S. D.,	*San Francisco*	23
Patrick, M. A.,	*Los Angeles*	10
Patterson, E. A.,	*Dos Palos*	13
Patterson, G. H.,	*Los Angeles*	10
Patterson, G. L.,	*Santa Rosa*	33
Patterson, J. A.,	*San Bernardino*	21
Patterson, J. K.,	*Santa Barbara*	27
Patton, E. F.,	*Los Angeles*	10
Patton, W. G.,	*Stockton*	24
Paul, S. B.,	*San Francisco*	23
Paull, R. A.,	*La Jolla*	22
Paup, M. K.,	*Kingman, Ariz.*	21
Paxman, D. G.,	*Oakland*	1
Pchelkin, N. A.,	*San Francisco*	23
Pearce, C. M.,	*Oakland*	1
Pearce, W. M.,	*Wilmington*	10
Pearl, F. A.,	*Los Angeles*	10
Pearl, F. L.,	*San Francisco*	23
Pearson, B. S.,	*Los Angeles*	10
Pearson, C. E.,	*Turlock*	34
Pearson, E. A.,	*Los Angeles*	10
Pearson, R. G.,	*Sacramento*	19
Peckham, G. M.,	*Oakland*	1
Peddicord, H.,	*Redwood City*	26
Peers, R. A.,	*Colfax*	17
Peers, R. S.,	*Oakland*	1
*Peery, J. T.,	*Corcoran*	8
Peery, L. T.,	*Berkeley*	1
Peirsol, E. C.,	*Claremont*	10
Peirsol, M.,	*Fresno*	4
Pelka, K. F.,	*Iowa City, Iowa*	28
Pelkan, K. F.,	*San Jose*	28
Peluso, J. D.,	*Los Angeles*	10
Pendergrass, C. I.,	*Clovis*	4
Pendergrass, J. E.,	*Clovis*	4
Pendleton, W. C.,	*Los Angeles*	10
Pendleton, W. R.,	*Long Beach*	10
Penn, H. S.,	*Los Angeles*	10
Penn, L. L.,	*San Francisco*	23
Pennington, A. S.,	*San Francisco*	23
Penzotti, R. B.,	*Oakland*	1
Peoples, S. Z.,	*Petaluma*	33
Peppers, C. H.,	*Los Angeles*	10
Percy, J. F.,	*Los Angeles*	10
Perkins, H. B.,	*Vallejo*	32
Perkins, W. A.,	*Oakland*	1
Perry, C. G.,	*Sausalito*	11
Perry, I. H.,	*San Francisco*	23
Perry, J. R.,	*West Hollywood*	10
Perry, O. H.,	*Yuba City*	39
Perzik, S. L.,	*Los Angeles*	10
Petch, P. H.,	*Oakland*	1
Peters, C.,	*San Francisco*	23
Peters, C. E.,	*Oakland*	1
Peters, H. E.,	*Pittsburg*	3
Peters, L.,	*Alameda*	1
Petersen, H. C.,	*Stockton*	24
Petersen, H. E.,	*San Fernando*	10
Peterson, A.,	*Los Angeles*	10
Peterson, A. A.,	*Los Angeles*	10
Peterson, E. A.,	*Vallejo*	32
Peterson, F. W.,	*El Centro*	6
Peterson, J. B.,	*Los Angeles*	10
Peterson, L. J.,	*Lodi*	24
Petr, F.,	*Turlock*	34
Petter, R. S.,	*Los Angeles*	10
Pettet, C. H.,	*Los Angeles*	10
Pettis, J. H.,	*Fresno*	4
Pettit, A. V.,	*San Francisco*	23
Pettler, S. H.,	*Los Angeles*	10
Petty, C. O.,	*Fullerton*	16
Pfeiffer, H. W.,	*La Mesa*	22
Pflueger, O. H.,	*San Francisco*	23
Phelan, C. A.,	*San Francisco*	23
Phelps, L. B.,	*Whittier*	10
Phetteplace, D. O.,	*Fullerton*	16
Phillips, A. D.,	*Sacramento*	19
Phillips, A. L.,	*Santa Cruz*	29
Phillips, C. E.,	*Los Angeles*	10
Phillips, L.,	*Hollywood*	10
Phillips, L. F. E.,	*Palo Alto*	28
Philp, W. S.,	*Los Angeles*	10
Pickard, R. J.,	*San Diego*	22
Pidcock, J. W.,	*Hollywood*	10
Pier, H. McK.,	*Oakland*	1
Pierce, G. W.,	*San Francisco*	23
Pierce, H. F.,	*Santa Barbara*	27
Pierce, S. N.,	*Los Angeles*	10
Pierson, P. H.,	*San Francisco*	23
Pillsbury, S. G.,	*Long Beach*	10
Pimentel, G. B.,	*Los Banos*	13
Pindell, M. L.,	*Los Angeles*	10
Pindler, L. A.,	*Los Angeles*	10
Piness, G.,	*Los Angeles*	10
Pinkerton, B. G.,	*Los Angeles*	10
Pinkham, C. B.,	*San Francisco*	23
Pinkley, V. M.,	*San Bernardino*	21
Pinney, I.,	*Stockton*	24
Piper, H. E.,	*Santa Cruz*	29
Pischel, D. K.,	*San Francisco*	23
Pischel, K.,	*San Francisco*	23
Pisciteli, A. M.,	*San Francisco*	23
Pitkin, H. C.,	*San Francisco*	23
Pitts, E. H.,	*Sacramento*	19
Pius, C.,	*Yreka*	31
Plane, J. F.,	*Long Beach*	10
Plank, T. H.,	*San Francisco*	23
Plath, H. W.,	*Oakland*	1
Platt, J. E.,	*Pasadena*	10
Player, L. P.,	*San Francisco*	23
Pleth, V.,	*Santa Rosa*	33
Plimpton, E. B.,	*Los Angeles*	10
Plumb, C. E.,	*Chico*	2
Plymire, D. B.,	*San Francisco*	23
Poage, C. A.,	*Colusa*	38
Podstata, V. H.,	*San Francisco*	1
Poheim, J. F.,	*San Francisco*	23
Polesky, F. A.,	*Iowa City, Iowa*	10
Poley, C. W.,	*Los Angeles*	10
Polland, W. S.,	*San Rafael*	11
Pollia, J. A.,	*Los Angeles*	10
Pollock, W. E.,	*Sacramento*	19
Pomeroy, F. K.,	*Fresno*	4
Pomeroy, G. T.,	*Napa*	15
Pomeroy, J. L.,	*Los Angeles*	10
Pond, S. B.,	*Patton*	21
Poole, F. E.,	*Glendale*	10
Poole, F. H.,	*Los Angeles*	29
Pope, W. H.,	*Sacramento*	19
Popkin, R. J.,	*Los Angeles*	10
Port, W. W.,	*San Francisco*	23
Porter, C. D.,	*San Francisco*	23
Porter, E. B.,	*Altadena*	22
Porter, E. E.,	*San Jose*	28
Porter, G. S.,	*Los Angeles*	10
Porter, J. A.,	*Modesto*	34
Porter, J. I.,	*Benicia*	32
Porter, M. E.,	*Camarillo*	37
Porter, R. L.,	*San Francisco*	23
Posner, C.,	*Pasadena*	10
Post, J. O.,	*Los Angeles*	10
Poston, H. P.,	*Pasadena*	10
Pottenger, F. M.,	*Monrovia*	10
Pottenger, F. M., Jr.,	*Monrovia*	10
Pottenger, J. E.,	*Monrovia*	10
Pottenger, R. T.,	*Pasadena*	10
Potter, A.,	*San Francisco*	23
Potter, C. D.,	*San Francisco*	23
Potter, G.,	*Oakland*	1
Potter, H. G.,	*Winters*	38
Potter, M. J. M.,	*San Diego*	22
Potter, W. H.,	*San Diego*	22
Pouppirt, P. S.,	*San Francisco*	23
Powell, A.,	*Lafayette*	1
Powell, B. J.,	*Stockton*	24
Powell, B. J., Jr.,	*Stockton*	24
Powell, D. R.,	*Stockton*	24
Powell, R. C.,	*Richmond*	3
Powell, T. O.,	*Los Angeles*	10
Powell, W. A.,	*Martinez*	3
Powers, A. R.,	*Tracy*	24
Powers, E. S.,	*Los Angeles*	10
Powers, H. J.,	*Beverly Hills*	10
Powers, R. A.,	*Palo Alto*	28
Pratt, B. H.,	*Lemoore*	8
Pratt, E. D.,	*Burbank*	10
Pratt, M. D.,	*Fall River Mills*	30
Pratt, O. B.,	*Los Angeles*	10
Pratt, T. R., Jr.,	*Pismo Beach*	25
Premo, M. A.,	*San Jose*	28
Presnell, J. F.,	*Los Angeles*	10
Pressley, J. F.,	*San Francisco*	23
Pressman, J. J.,	*Los Angeles*	10
Preston, A. W.,	*Visalia*	36
Preston, H. E.,	*Los Angeles*	10
Preuss, C. A.,	*Santa Barbara*	27
Price, J. B.,	*Santa Ana*	16
Price, L. G.,	*Fresno*	4
Prien, R. H.,	*Gilroy*	28
Priestley, S. F.,	*Stockton*	24
Prigge, E. K.,	*Los Angeles*	10
Primasing, R.,	*Courtland*	19
Prince, C. C.,	*Glendale*	10
Prince, L. D.,	*San Francisco*	23
Prince, P. W.,	*Long Beach*	10
Prince, R. W.,	*San Bernardino*	21
Prindle, K. H.,	*San Mateo*	26
Prisinzano, G.,	*Sacramento*	19
Pritchard, F. H.,	*Colton*	21
Pritchard, J. L.,	*San Jose*	28
Pritchard, W. F.,	*San Bernardino*	21
Probert, W. H.,	*Berkeley*	1
Proescher, F.,	*San Jose*	28
Profant, H. J.,	*Santa Barbara*	27
Pruett, H. J.,	*San Francisco*	23
*Pruett, J. F.,	*San Francisco*	23
Pryor, H. B.,	*Palo Alto*	28
Pulford, D. S.,	*Sacramento*	19
Purdy, A. P.,	*San Francisco*	23
Purlenky, G. P.,	*Arcata*	5
Pursell, F. J.,	*Los Angeles*	10
Purviance, C. C.,	*Fairfield*	32
Putnam, H. A.,	*Monrovia*	10
Putnam, V.,	*San Francisco*	23

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NAME	CITY	COUNTY SOCIETY NO.
Qualntance, P. A.,	*Los Angeles*	10
Quarry, P. T.,	*Santa Rosa*	33
Quigley, J. S.,	*Oakland*	1
Quimby, S. A.,	*Madera*	4

NAME	CITY	COUNTY SOCIETY NO.
Quinan, C.,	*Nevada City*	17
Quinlan, C. M.,	*Santa Rosa*	33
Quinlan, J. F.,	*San Francisco*	23
Quinn, E. M.,	*San Francisco*	32
Quinn, T. D'A.,	*San Francisco*	23
Quinn, V. J.,	*Los Angeles*	10
Quinn, W. F.,	*Los Angeles*	10
Quinn, W. J.,	*Eureka*	5
Quirmbach, R. P.,	*Spadra*	23

— R —

Rabinowitz, R.,	*San Francisco*	23
Rabwin, M. H.,	*Los Angeles*	10
Racer, F. H.,	*Lomita*	10
Rachmel, W.,	*Los Angeles*	10
Radford, E. B.,	*Walnut Creek*	3
Ragan, S. T.,	*Los Angeles*	10
Rallsback,, O. C.,	*Woodland*	38
Raitt, G. E.,	*Santa Ana*	16
Rajotte, E. C. F.,	*San Francisco*	23
Rambo, W. H.,	*Los Angeles*	10
Rammelt, W.,	*Los Angeles*	10
Ramsay, R. E.,	*Pasadena*	10
Rand, C. W.,	*Los Angeles*	10
Randall, D. T.,	*West Los Angeles*	10
Randall, S. B.,	*Santa Cruz*	29
Randel, H. A.,	*Fresno*	4
Raney, R. B.,	*Los Angeles*	10
Ranker, E. R.,	*Oakland*	1
Rankin, E. P.,	*Berkeley*	1
Rankin, T. J.,	*San Diego*	22
Ransom, D. H.,	*Madera*	4
Ransom, J. K.,	*Modesto*	34
Ranson, J. R.,	*San Luis Obispo*	25
Rapaport, H.,	*Los Angeles*	10
Rapaport, W.,	*Imola*	15
Raphael, J. C.,	*Oakland*	1
Rasor, C.,	*Oakland*	1
Rathbone, R. H.,	*Los Angeles*	10
Ratliff, H. L.,	*Riverside*	18
Ratner, R.,	*San Francisco*	23
Ratty, F. J.,	*San Diego*	22
Raulston, B. O.,	*Los Angeles*	10
Ravenscroft, J. W.,	*San Diego*	22
Rawlins, A. G.,	*San Francisco*	23
Ray, E. B.,	*Bellflower*	10
Ray, F. S.,	*Los Angeles*	10
Ray, H. H.,	*San Mateo*	26
Ray, L.,	*Santa Rosa*	33
Raymond, A.,	*San Francisco*	23
Rea, B. J.,	*Sacramento*	19
Rea, J. G.,	*Pomona*	10
Rea, R. R.,	*Los Angeles*	10
Rea, S. L.,	*Ukiah*	12
*Rea, T.,	*Yreka*	31
Read, F. T.,	*Glendale*	10
Read, J. M.,	*San Francisco*	23
Ready, F. L.,	*Los Angeles*	10
Ream, M. P.,	*San Leandro*	1
Reamer, E. F.,	*Modesto*	34
Reardon, F. B.,	*Sacramento*	19
Reasner, W. F.,	*Santa Monica*	10
Rebec, W. G.,	*Belmont*	26
Reckers, W. A.,	*Placerville*	19
Rector, J. M.,	*San Francisco*	23
Redelings, L. H.,	*San Diego*	22
Redewill, F. H.,	*San Francisco*	23
Redfield, R. L.,	*Berkeley*	1
Redmond, M. H.,	*Huntington Park*	10
Reed, A. C.,	*San Francisco*	23
Reed, C. C.,	*Compton*	10
Reed, E. N.,	*Santa Monica*	10
Reed, J. R.,	*Pasadena*	10
Reed, W. W.,	*Nevada City*	17
Reeder, C. W.,	*Long Beach*	10
Reeng, J. D.,	*San Francisco*	23
Rees, C. E.,	*San Diego*	22
Rees, C. W.,	*San Diego*	22
Rees, D. M.,	*Monterey Park*	10
Rees, H. C.,	*Los Angeles*	10
Rees, R. B.,	*Bakersfield*	7
Reeves, E. W.,	*Salinas*	14
Reeves, J. E.,	*San Diego*	22
Reeves, J. M.,	*Oakland*	1
Reeves, J. W.,	*Los Angeles*	10
Reeves, W. R.,	*Salinas*	14
Regan, L. J.,	*Los Angeles*	10
Reich, A., Jr.,	*San Francisco*	28
Reich, W. W.,	*Berkeley*	1
Reiche, C.,	*Los Angeles*	10
Reichert, F. L.,	*San Francisco*	23
Reichle, P. A.,	*Los Angeles*	10
Reid, R. B.,	*Beaumont*	18
Reid, R. S.,	*Oceanside*	22
Reilly, P. H.,	*Vallejo*	32
Reilly, W.,	*San Francisco*	23
Reilly, W. A.,	*San Francisco*	23
Reina, S.,	*Los Angeles*	10
Reinard, E.,	*Los Angeles*	10
Reinertsen, B. R.,	*Los Angeles*	10
Reinle, G. G.,	*Oakland*	1
Reis, A. G. DeS.,	*Oakland*	1
Reische, A. E.,	*Oakland*	1
Reiss, O.,	*Los Angeles*	10
Reiss, T. H.,	*Alameda*	1
Reitzel, R. J.,	*San Mateo*	26
Remaly, C. E.,	*Los Angeles*	10
Remington, L. D.,	*Monrovia*	10
Remmel, A. J.,	*San Francisco*	23
Remmen, E. T.,	*Glendale*	10
Renner, J. H.,	*Santa Barbara*	27
Renshaw, J. F.,	*Los Angeles*	10
Replogle, E. G.,	*Los Angeles*	10
Ress, I. LeR.,	*Los Angeles*	10
Rethwilm, L. A.,	*San Francisco*	23
Reud, W. R.,	*Oakland*	1
Rey, H. F.,	*Oxnard*	37
Reyes, J. M. de l.,	*Los Angeles*	10
Reynolds, C. E.,	*Glendale*	10
Reynolds, F. C.,	*Chico*	2
Reynolds, F. G.,	*Los Angeles*	10
Reynolds, H. C.,	*Arlington*	18
Reynolds, J.,	*Los Angeles*	10
Reynolds, J. M.,	*Long Beach*	10
Reynolds, L. G.,	*Los Angeles*	10
Reynolds, L. R.,	*San Francisco*	23
Reynolds, P. A.,	*Los Angeles*	10
Reynolds, R. A.,	*San Francisco*	23
Reynolds, T. E.,	*Oakland*	1
Reznick, S.,	*Los Angeles*	10
Rhind, R.,	*Hermosa Beach*	10
Rhodes, G. K.,	*San Francisco*	23
Rhone, T. B.,	*Orange*	16
Rhymes, L. H.,	*Canoga Park*	10
Riach, M. T.,	*San Diego*	22
Rice, A. H.,	*Woodland*	23
Rice, C. H.,	*Oakland*	1
Rice, F. M.,	*San Francisco*	23
Richards, C. M.,	*San Jose*	28
Richards, D. N.,	*Oakland*	1
Richards, J. C.,	*Inglewood*	10
Richards, S. B.,	*San Bernardino*	21
Richardson, G. C.,	*Sonora*	24
Richardson, W. A.,	*Loma Linda*	21
Richtel, P.,	*Fresno*	4
Richter, C.,	*Balboa Beach*	16
Richter, I. M.,	*Santa Barbara*	27
Rickabaugh, H. B.,	*Alhambra*	10
Riddell, O. J.,	*Alhambra*	10
Riggin, L. L.,	*Pasadena*	10
Riggle, O.,	*Lodi*	24
Righetti, E.,	*San Francisco*	23
Righetti, H.,	*San Francisco*	23
Rinehart, J. F.,	*San Francisco*	23
Rinkenberger, F. W.,	*Los Angeles*	10
Risley, E. H.,	*Loma Linda*	21
Risser, J. C.,	*Pasadena*	10
Ritchie, I. S.,	*Riverside*	18
Rivin, H. A.,	*Delano*	7
Rixford, E.,	*San Francisco*	23
Rixford, E. L., Jr.,	*San Francisco*	23
Rixford, H. C.,	*Stockton*	24
Roath, C. A., Jr.,	*Los Angeles*	10
Robarts, H. P.,	*San Francisco*	23
Robbins, A. C.,	*Garden Grove*	16
Robbins, A. R.,	*Los Angeles*	10
Robbins, B.,	*Hanford*	8
Robbins, D. R.,	*Los Angeles*	10
Roberg, D. N.,	*San Jose*	28
Roberts, A. M.,	*Los Angeles*	10
Roberts, E. K.,	*Los Angeles*	10
Roberts, G. J.,	*Pomona*	10
Roberts, G. W.,	*Oakland*	1
Roberts, J. G.,	*Pomona*	10
Roberts, W. H.,	*Pasadena*	10
Robertson, D. L.,	*Modesto*	34
Robertson, H. R.,	*Los Angeles*	10
Robertson, J. C.,	*Modesto*	34
Robertson, J. W., Jr.,	*Livermore*	1
Robertson, R. R.,	*San Rafael*	11
Robinson, H. H.,	*Oakland*	1
Robinson, J.,	*Anaheim*	16
Robinson, J. H.,	*Los Angeles*	10
Robinson, J. M.,	*San Francisco*	23
Robinson, J. W.,	*Los Angeles*	10
Robinson, L. L.,	*San Rafael*	11
Robinson, S. P.,	*Santa Barbara*	27
Robinson, S. S.,	*Los Angeles*	10
Robison, L. H.,	*Los Angeles*	10
Roblee, W. W.,	*Riverside*	18
Robson, G. B.,	*San Francisco*	23
Rochex, F. J.,	*San Francisco*	23
Rodenbaugh, F. H.,	*San Francisco*	23
Rodin, F. H.,	*San Francisco*	23
Roe, H. E.,	*Berkeley*	1
Roen, P. B.,	*Hollywood*	10
Roger, J. H. D.,	*San Francisco*	23
Rogers, E. L.,	*Loma Linda*	21
Rogers, H.,	*Oakland*	1
Rogers, H. S.,	*Petaluma*	33
Rogers, J. A.,	*San Francisco*	23
Rogers, J. B.,	*Napa*	15
Rogers, J. B.,	*Los Angeles*	10
Rogers, J. D.,	*Los Angeles*	10
Rogers, L. B.,	*Los Angeles*	10
Rogers, L. E.,	*Los Angeles*	10
Rogers, S.,	*Tulare*	36
Rogers, T. J.,	*Los Angeles*	10
Rogers, T. L.,	*Long Beach*	10
Rogers, W. C.,	*Pasadena*	10
Rogers, W. G.,	*Los Angeles*	10
Rogers, W. L.,	*San Francisco*	23
Rohlfes, B. J.,	*San Francisco*	23
Rohrbacher, G. H.,	*Stockton*	24
Rolland, W. M.,	*Los Angeles*	10
Roller, C. S.,	*Woodland*	38
Rolph, W. D.,	*National City*	22
Roncovleri, L.,	*San Francisco*	23
Rood, R. S.,	*Davenport*	29
Rood, V. V.,	*Grass Valley*	17
*Rook, C. W.,	*Montrose*	10
Roome, C. T.,	*Santa Barbara*	27
Rooney, C. E.,	*Santa Monica*	10
Rooney, H. M.,	*Los Angeles*	10
Roos, A. R.,	*Loma Linda*	21
Roos, D. D.,	*Corona*	18
Roos, V. O.,	*Redlands*	21
Root, P. N.,	*Bakersfield*	7
Root, R. R.,	*Corona*	18
Rosanoff, A. J.,	*Los Angeles*	10
Rosasco, J. L.,	*Stockton*	24
Rosasco, O. L.,	*Saratoga*	28
Rosburg, A. H.,	*San Francisco*	23
Roscoe, A. M.,	*Newman*	34
Rose, C. M.,	*Los Angeles*	10
Rose, H. de W.,	*Sonora*	24
Rose, J. T.,	*Healdsburg*	33
Rose, L. M.,	*Santa Clara*	28
Rosenberg, M. N.,	*Los Angeles*	10
Rosenberg, M. W.,	*Los Angeles*	10
Rosenberger, H. G.,	*Whittier*	10
Rosenblatt, J.,	*Duarte*	10
Rosenbloom, D.,	*Los Angeles*	10
Rosenblum, D. H.,	*Los Angeles*	10
Rosenblum, H. H.,	*San Francisco*	23
Rosencrantz, E.,	*San Francisco*	23
Rosenfeld, M. H.,	*Los Angeles*	10
Rosenkranz, H. A.,	*Los Angeles*	10
Rosenthal, A. G.,	*San Francisco*	23
Rosenthal, A. M.,	*Los Angeles*	10
Rosove, L.,	*Santa Monica*	10
Ross, A.,	*Los Angeles*	10
Ross, D. E.,	*Los Angeles*	10
Ross, K. F.,	*Los Angeles*	10
Ross, M. H.,	*Los Angeles*	10
Ross, P.,	*Richmond*	3
Ross, S. G.,	*Pasadena*	10
Ross, V. R.,	*Stockton*	24
Rosson, C. T.,	*Hanford*	8
Rosson, C. T., Jr.,	*Hanford*	8
Rosson, R. W.,	*Tulare*	36
Roth, E. F.,	*Palo Alto*	28
*Roth, G. H.,	*Los Angeles*	10
Roth, H. A.,	*Long Beach*	10
Rothman, P. E.,	*Los Angeles*	10
Rothwell, W. T.,	*Los Angeles*	10
Rouff, E.,	*San Jose*	28
Rover, H. P.,	*Los Angeles*	10
Row, C. F.,	*Santa Monica*	10
Rowan, E. J.,	*Wilmington*	10
Rowe, A. H.,	*Oakland*	1
Rowe, M. J.,	*Norwalk*	10
Rowell, H. N.,	*Berkeley*	1
Rowell, W. A.,	*Trinity Center*	30
Royer, J. E.,	*Oakland*	1
Royston, E. A.,	*Los Angeles*	10
Rubensteln, C. L.,	*San Francisco*	23
Rubin, J. S.,	*Los Angeles*	10
Rubinstein, I.,	*Los Angeles*	10
Rubinstein, V. G.,	*Los Angeles*	10
Ruddock, J. C.,	*Los Angeles*	10
Ruddy, L. W.,	*Sacramento*	19
Rude, A. E.,	*Los Angeles*	10
Rue, H. A.,	*Los Angeles*	10
Ruediger, E. H.,	*San Diego*	22
Rueter, K.,	*Oakland*	1
Ruff, F. R.,	*Fresno*	4
Ruggles, H. E.,	*San Francisco*	23
Rukke, G. V.,	*Monterey*	14
Rukke, R. V.,	*Monterey*	14
Rulison, E. T.,	*Sacramento*	19
Rumph, P. E.,	*Orange*	16
Runckel, G. H.,	*McCloud*	31
Runner, J. F.,	*San Francisco*	23
Runyon, L. A.,	*Westwood*	9
Rupp, J. J.,	*Santa Barbara*	27
Rusche, C. F.,	*Hollywood*	10
Rush, R. C.,	*San Fernando*	10
Russell, E. L.,	*Santa Ana*	16
Russell, J. A.,	*Auburn*	17
Russell, J. P.,	*Berkeley*	26
Russell, R.,	*Glendale*	10
Russell, T. C.,	*Tracy*	24
Russell, W. W.,	*San Diego*	22
Ruth, E. S.,	*Hollywood*	10
Ruth, G. D.,	*Los Angeles*	10
Rutherford, F. de P.,	*Santa Clara*	28
Ryan, A. F.,	*Los Angeles*	10
Ryan, A. J.,	*Vallejo*	32
Ryan, A. M.,	*San Francisco*	23
Ryan, C. D.,	*Beverly Hills*	10
Ryan, F. S.,	*San Jose*	28
Ryan, R. C.,	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
Ryan, W. J.,	*San Diego*	22
Ryder, B. E.,	*Los Angeles*	10
Rypins, R. F.,	*San Francisco*	23
Rytand, D. A.,	*San Francisco*	23

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Saam, J. G.,	*Oakland*	1
Sabichi, G. C.,	*Claremont*	10
Saeltzer, D. V.,	*Sacramento*	19
Safarik, E. S.,	*Los Angeles*	10
Saffro, L. B.,	*San Pedro*	10
Saier, M. H.,	*Palo Alto*	28
Sale, J. J.,	*San Francisco*	23
Salisbury, C. S.,	*Los Angeles*	10
Salomon, E.,	*San Francisco*	23
Salomon, W.,	*Los Angeles*	10
Salter, N. M.,	*Williams*	38
Salvin, M.,	*Los Angeles*	10
Sample, T. N.,	*Fresno*	4
Sampson, J. A.,	*Los Angeles*	10
Sampson, J. J.,	*San Francisco*	23
Sampson, J. P.,	*Santa Monica*	10
Sampson, M. H.,	*Berkeley*	1
Sampson, P. M.,	*Long Beach*	10
Sampson, W. A.,	*San Francisco*	23
Samson, P. C.,	*Oakland*	1
Sanderson, G. H.,	*Stockton*	24
Sandholt, J. P.,	*Monterey*	14
Sandie, J.,	*Los Angeles*	10
Sands, R. A.,	*Ocean Park*	10
Sands, R. L.,	*Santa Monica*	10
Sands, R. L.,	*Santa Monica*	10
Sanford, H. E.,	*Montrose*	10
Sanford, J. R.,	*Pasadena*	10
Sansum, W. D.,	*Santa Barbara*	27
Sappington, E. E.,	*San Francisco*	23
Sargent, W. H.,	*Oakland*	1
Sarkisian, M.,	*Sacramento*	19
Sartori, H. J.,	*San Francisco*	23
Sasso, J. A.,	*Los Angeles*	10
Satterlee, W. C.,	*San Diego*	22
Sauber, I. E.,	*Los Angeles*	10
Sauer, F. J.,	*Los Angeles*	10
Sauer, F. K.,	*Los Angeles*	10
Saunders, C. E.,	*San Jose*	28
Savage, J. C.,	*Los Angeles*	10
Savage, P. M.,	*San Bernardino*	21
Savage, P. M., Jr.,	*San Bernardino*	21
Savage, S. H.,	*Lancaster*	10
Savage, W. W.,	*San Bernardino*	21
Saverien, A. E.,	*Los Angeles*	10
Saverien, H. L.,	*Fair Oaks*	19
Sawtelle, H. F.,	*Arroyo Grande*	25
Sawyer, F. E.,	*Oakland*	1
Sawyer, L.,	*San Francisco*	23
Saxon, A.,	*Los Angeles*	10
Saylin, G. J.,	*Los Angeles*	10
Saylin, J.,	*Venice*	10
Saylor, B. F.,	*Redding*	30
Scamell, J. W.,	*Oakland*	1
Scanland, J. M.,	*Imola*	15
Scanlon, W. G.,	*Pasadena*	10
Scarboro, E. R.,	*Fresno*	4
Scarborough, R. A.,	*San Francisco*	23
Scatena, F. N.,	*Sacramento*	19
Schaefer, J. H.,	*Sacramento*	10
Schaefer, J. W.,	*Los Angeles*	10
Schaeffer, R. W.,	*Redondo Beach*	10
Schaller, W. F.,	*San Francisco*	23
Schallig, D. W.,	*Sacramento*	19
Schaper, E. A.,	*San Leandro*	7
Schatz, M. M.,	*Fresno*	4
Schaupp, K. L.,	*San Francisco*	23
Schefcik, J. F.,	*Los Angeles*	10
Scheier, R. B.,	*San Francisco*	23
Schell, J. P.,	*San Jose*	28
Schenck, G. F.,	*Los Angeles*	10
Schield, E. LeR.,	*Pomona*	10
Schiff, M. J.,	*Los Angeles*	10
Schiffbauer, H. E.,	*Los Angeles*	10
*Schiller, M. M.,	*Los Angeles*	10
Schilling, C. F.,	*Pacific Grove*	14
Schilling, W.,	*San Francisco*	23
Schlageter, H. J.,	*San Francisco*	23
Schlappi, J. C.,	*San Diego*	22
Schlesinger, E. R.,	*Los Angeles*	10
Schlotthauer, H. L.,	*Tehachapi*	7
Schlotthauer, M. Q.,	*Tehachapi*	7
Schluter, H. F.,	*Sacramento*	19
Schmelz, C. J.,	*Guerneville*	33
Schmerl, E. F.,	*Oakland*	1
Schmid, C. F.,	*Hermosa Beach*	10
Schmidt, A. E.,	*San Francisco*	23
Schmidt, D. A.,	*Los Angeles*	10
Schmidt, D. G.,	*San Quentin*	11
Schmidt, E. J.,	*Fresno*	4
Schmidt, F. M.,	*Los Angeles*	10
Schmidt, P. E.,	*Glendale*	10
Schmitt, E. O. G.,	*San Jose*	28
Schmitt, H. H.,	*Gilroy*	28
Schmitt, L. S.,	*San Francisco*	23
Schmoele, J. M.,	*Los Angeles*	10
Schneider, E. G.,	*San Francisco*	23
Schneider, E. H.,	*Los Angeles*	10
Schneiders, R. A.,	*San Diego*	22
Schoff, C. E.,	*Sacramento*	19
Schofield, R. O.,	*Sacramento*	19
Scholl, A. J.,	*Los Angeles*	10
Scholtz, J. R.,	*Los Angeles*	10
Scholz, A. M.,	*Los Angeles*	10
Schomaker, T. P.,	*San Francisco*	23
Schoonmaker, G. D.,	*San Francisco*	23
Schott, H. J.,	*Los Angeles*	10
Schottstaedt, W. E. R.,	*Fresno*	4
Schreiber, L. W.,	*Beverly Hills*	10
Schriber, P. W.,	*Atwater*	13
Schroeder, F. B.,	*San Diego*	22
Schroer, W. J.,	*Orange*	16
Schueler, L. A.,	*Beverly Hills*	10
Schuetz, C. E.,	*Hollywood*	10
Schultz, C. E.,	*Castroville*	14
Schultz, H.,	*Downey*	10
Schultz, H. H.,	*San Francisco*	23
Schultz, L. O.,	*Glendale*	10
Schulz, R. L.,	*Los Angeles*	10
Schulze, M.,	*San Francisco*	23
Schumacher, I. C.,	*San Francisco*	23
Schurmeier, H. L.,	*Santa Barbara*	27
Schussler, H., Jr.,	*San Francisco*	23
Schwalenberg, H. R.,	*Santa Barbara*	27
Schwartz, A. H.,	*Beverly Hills*	10
Schwartz, D. Z.,	*Los Angeles*	10
Schwartz, F. L.,	*San Diego*	22
Schwartz, I.,	*San Francisco*	23
Schwarz, I.,	*San Francisco*	23
Schwarz, T. E.,	*Oakland*	1
Schwuchow, W. B.,	*Los Angeles*	10
Sciaroni, G. H.,	*Fresno*	4
Scobee, J. E.,	*Los Angeles*	10
Scoins, W. H.,	*Los Angeles*	10
Scott, A. J., Jr.,	*Los Angeles*	10
Scott, F. L.,	*Los Angeles*	10
Scott, J. T.,	*San Diego*	22
Scott, R. R.,	*Selma*	4
Scott, W. E.,	*San Francisco*	23
Scovel, R. E.,	*San Francisco*	23
Scribner, R. G.,	*Sacramento*	19
Scroggy, J. Q. A.,	*Los Angeles*	10
Scudder, R.,	*Fort Bragg*	12
Scuderi, S. A.,	*Los Angeles*	10
Seabolt, G. C.,	*South Pasadena*	10
Seals, P. W.,	*Los Angeles*	10
Searls, H. H.,	*San Francisco*	23
Seaver, H. C.,	*Los Angeles*	10
Seavey, M. A.,	*Sacramento*	19
*Seawell, J. W.,	*Healdsburg*	33
Sebastian, C. F.,	*Los Angeles*	10
Sedgwick, V. de M.,	*Long Beach*	10
Seeburt, E. M. P.,	*San Francisco*	23
Seech, S. G.,	*Los Angeles*	10
Seeley, L. J.,	*San Carlos*	30
Seeley, P. A.,	*Burlingame*	26
Segall, G.,	*Los Angeles*	10
Seiberth, J.,	*Pixley*	36
Seid, M. J.,	*San Francisco*	23
Seiger, H. W.,	*Ocean Park*	21
Seitz, R. P.,	*San Francisco*	23
Sekiyama, I.,	*Los Angeles*	10
Seletz, E.,	*Los Angeles*	10
Seletz, R.,	*Los Angeles*	10
Seligman, L. J.,	*Los Angeles*	10
Sellery, A. C.,	*Long Beach*	10
Sellery, C. M.,	*Los Angeles*	10
Sellew, P. K.,	*Los Angeles*	10
Sellon, G. I.,	*Fullerton*	16
Semenov, H.,	*Los Angeles*	10
Senseman, W. R.,	*Palmdale*	10
Servin, C.,	*Los Angeles*	10
Settle, F. B.,	*Long Beach*	10
Setzler, G. B.,	*Los Angeles*	10
Sevenman, G. W.,	*San Mateo*	26
Sevier, E.,	*Sacramento*	19
Sewall, E. C.,	*San Francisco*	23
Seymour, E. C.,	*Olive View*	10
Shackford, B. C.,	*Long Beach*	10
Shade, M. A.,	*Oakland*	1
Shafer, F. P.,	*Los Angeles*	10
Shaffer, C. J.,	*Huntington Park*	10
Shafor, H. A.,	*Los Angeles*	10
Shaghojan, A. H.,	*Daly City*	26
Shahovitch, G. P.,	*Los Angeles*	10
Shambaugh, N. F.,	*Long Beach*	10
Sharp, G. S.,	*Pasadena*	10
Sharp, J. C.,	*Salinas*	14
Sharp, J. G.,	*San Francisco*	23
Sharp, K. F.,	*Fresno*	4
Sharp, R. G.,	*San Diego*	22
Sharpe, O. A.,	*San Francisco*	26
Sharpsteen, J. R.,	*Oakland*	1
Shattuck, H. P.,	*Los Angeles*	10
Shaull, E. M.,	*Palo Alto*	28
Shaw, E. B.,	*San Francisco*	23
Shaw, H. N.,	*Los Angeles*	10
Shaw, L. O.,	*Walnut Park*	10
Shea, J. J.,	*San Diego*	22
Shea, T. T.,	*San Francisco*	23
Sheafe, E. V.,	*Oakland*	1
Sheehy, F. T.,	*San Francisco*	23
Sheets, O. B.,	*Los Angeles*	10
Sheets, W. T.,	*W. Los Angeles*	10
Shelby, D. C.,	*Los Angeles*	10
Sheld-Ritchie, L.,	*Riverside*	18
Sheldon, E. A.,	*Bellflower*	10
Sheldon, E. C.,	*Hollister*	20
Sheldon, E. F.,	*Los Angeles*	2
Sheldon, F. B.,	*Pasadena*	16
Sheldon, R. F.,	*Long Beach*	10
Sheller, W. O.,	*Long Beach*	10
Shelton, E. K.,	*Santa Barbara*	27
Shelton, G. C.,	*Los Angeles*	10
Shelton, V. G.,	*Hollywood*	10
Shenk, F. P.,	*Santa Cruz*	29
Shepard, W. P.,	*San Francisco*	23
Shepardson, H. C.,	*San Francisco*	23
Shephard, J. H.,	*San Jose*	28
Shepherd, H. L.,	*Los Angeles*	10
Sher, B. H.,	*Los Angeles*	10
Sheranian, H. N.,	*Los Angeles*	10
Sherman, B. H.,	*Hollywood*	10
Sherman, E. C., Jr.,	*Cambria*	25
Sherman, J.,	*San Francisco*	23
Sherman, R. S.,	*San Francisco*	23
Sherrard, E. E.,	*Los Angeles*	10
Sherrick, J. W.,	*Oakland*	1
Sherrill, J. W.,	*La Jolla*	22
Sherry, L. B.,	*Pasadena*	10
*Shidler, G. P.,	*Torrance*	10
Shields, L.,	*Oakland*	1
Shiels, G. F.,	*Redwood City*	26
Shilling, J. W.,	*Los Angeles*	10
Shimkin, L.,	*San Francisco*	23
Shipley, R. E.,	*Los Angeles*	10
Shipley, W. C.,	*Santa Rosa*	33
Shipman, S. J.,	*San Francisco*	23
Shippey, R. H.,	*Long Beach*	10
Shirey, C. W.,	*North Hollywood*	10
Shirk, F. M.,	*La Verne*	10
Shoemaker, H.,	*Los Angeles*	10
Shone, L. B.,	*San Francisco*	23
Shook, F. M.,	*Oakland*	1
Shore, F. A.,	*Ventura*	37
Shore, S.,	*Los Angeles*	10
Shorkley, T. M.,	*Carpinteria*	27
Short, J. E.,	*Los Angeles*	10
Shreck, J. A.,	*Redlands*	21
Shryock, E. H.,	*Loma Linda*	21
Shryock, A.,	*Loma Linda*	21
Shuck, C. H.,	*Fresno*	4
Shufelt, A. A.,	*San Jose*	28
Shulman, L.,	*Los Angeles*	10
Shultz, E. L.,	*Los Angeles*	10
Shumaker, E. K.,	*Los Angeles*	10
Shumaker, P. R.,	*Stockton*	24
Shumaker, P. W.,	*Los Angeles*	10
Shuman, J. W.,	*Los Angeles*	10
Shumate, C. A.,	*New York, N. Y.*	23
Shumate, F. O.,	*San Francisco*	23
Shumate, T. E.,	*San Francisco*	23
Shutes, M. H.,	*Oakland*	1
Sicherman, K. L.,	*Los Angeles*	10
Sides, H. E.,	*Huntington Park*	10
Siefert, A. C.,	*Oakland*	1
Siegel, L. E.,	*Beverly Hills*	10
Siegmund, F. W.,	*Los Angeles*	10
Sigworth, D. C.,	*Long Beach*	10
Sills, S. J.,	*Los Angeles*	10
Silver, B.,	*Los Angeles*	10
Silverberg, M. H.,	*San Francisco*	23
Silverman, D. J.,	*Los Angeles*	10
Silvia, C. A.,	*Gilroy*	28
Simmons, H. M.,	*Willows*	38
Simms, J. S.,	*Bellflower*	10
Simon, J.,	*Los Angeles*	10
Simons, C. G.,	*No. Hollywood*	10
Simonds, P. E.,	*Riverside*	18
Simpson, B.,	*San Francisco*	23
Simpson, B. R.,	*San Diego*	22
Sinclair, A. D.,	*San Francisco*	23
Singer, H.,	*Los Angeles*	10
Singer, J. J.,	*Los Angeles*	10
Singerman, I.,	*Los Angeles*	10
Sink, W. D.,	*Santa Maria*	27
Sipman, H.,	*Oakland*	1
Sippy, J. J.,	*Stockton*	24
Sirbu, A. B.,	*San Francisco*	23
Sisson, C. E.,	*Los Angeles*	22
Sisson, M.,	*Oakland*	1
Skaff, J. E.,	*San Francisco*	23
Skaleter, E. A.,	*Los Angeles*	10
Skancky, A. O.,	*San Bruno*	26
Skeel, D. W.,	*Los Angeles*	10
Skelly, J. F.,	*San Francisco*	23
Skelton, L. W.,	*Pasadena*	10
Skillen, J.,	*Olive View*	10
Skilling, L. E.,	*Alameda*	1
Slagerman, V. B.,	*Los Angeles*	10
Slater, H. M.,	*Palo Alto*	28
Slater, V. G.,	*San Bernardino*	21
Slattery, J. W.,	*Mountain View*	28
Slaughter, H. C.,	*Los Angeles*	10
Slavich, J. F.,	*Oakland*	1
Slemons, J. M.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Slepnikoff, S. F.,	*San Francisco*	23
Sloan, L. E.,	*Inglewood*	10
Sloan, O. J.,	*Glendale*	10
Sloane, L. O.,	*Los Angeles*	10
Smale, G. A.,	*Los Angeles*	10
Small, C. K.,	*Oakland*	1
Smallberg, H. E.,	*W. Hollywood*	10
Smalley, R. B.,	*Willits*	12
Smallwood, W. C.,	*Long Beach*	10
Smart, E. P.,	*Murphy*	24
Smart, R. H.,	*Los Angeles*	10
Smedley, R. C.,	*Los Angeles*	10
Smiley, H. W.,	*Indio*	18
Smiley, K. E.,	*Los Angeles*	10
Smitgen, P. H.,	*Inglewood*	10
Smith, A. B.,	*La Jolla*	22
Smith, A. E.,	*Los Angeles*	10
Smith, A. M.,	*Oakland*	1
*Smith, A. S. J.,	*San Jose*	28
Smith, B.,	*Los Angeles*	10
Smith, B. H.,	*Santa Monica*	10
Smith, B. H.,	*Huntington Park*	10
Smith, C. E.,	*San Francisco*	23
Smith, C. L.,	*Maywood*	10
Smith, C. R.,	*Los Angeles*	10
Smith, D. A.,	*Oakland*	23
Smith, D. D.,	*San Diego*	22
Smith, D. V.,	*Long Beach*	10
Smith, E. D.,	*Solvang*	27
Smith, E. G.,	*Oakland*	1
Smith, E. W.,	*San Francisco*	11
Smith, F. H.,	*Salinas*	14
Smith, F. H.,	*San Bruno*	26
Smith, F. L.,	*Colfax*	36
Smith, F. M.,	*La Jolla*	22
Smith, G. F.,	*Los Angeles*	10
Smith, H.,	*Los Angeles*	10
Smith, H. A.,	*Whittier*	10
Smith, H. C.,	*Glendale*	10
Smith, H. D.,	*Pomona*	10
Smith, H. G.,	*Palo Alto*	28
Smith, H. J.,	*Oakland*	1
*Smith, H. L.,	*Fair Oaks*	19
Smith, H. MacV.,	*Santa Ana*	16
Smith, J. J.,	*Los Angeles*	10
Smith, J. J. H.,	*Colton*	21
Smith, J. L.,	*Los Angeles*	10
Smith, J. O.,	*San Francisco*	23
Smith, J. R.,	*San Francisco*	4
Smith, K. B.,	*Oakland*	1
Smith, L. D.,	*Stockton*	24
Smith, L. E.,	*Hollister*	20
Smith, L. E.,	*San Bernardino*	21
Smith, L. W.,	*Los Angeles*	10
*Smith, M.,	*Los Angeles*	10
Smith, M. H.,	*Hollywood*	10
Smith, N. R.,	*Monterey Park*	10
Smith, P. M.,	*San Francisco*	23
Smith, R. D.,	*Pomona*	10
Smith, R. D.,	*San Pedro*	10
*Smith, R. K.,	*San Francisco*	23
Smith, R. L.,	*Santa Monica*	10
Smith, R. L.,	*Pomona*	10
Smith, R. L. I.,	*Pasadena*	10
Smith, R. M.,	*Riverside*	18
Smith, R. N.,	*Los Angeles*	10
Smith, R. T.,	*Pomona*	10
Smith, R. T.,	*Palo Alto*	28
Smith, S.,	*Pasadena*	10
Smith, S. K.,	*Oakland*	1
Smith, T. B.,	*Wilmington*	10
Smith, W.,	*Los Angeles*	10
Smith, W. B.,	*Los Angeles*	10
Smith, W. B.,	*San Francisco*	23
Smith, W. B.,	*Delano*	7
Smith, W. S.,	*San Diego*	22
Smithies, H. R.,	*Alameda*	1
Smolt, C. A.,	*Ventura*	37
Smolt, L. P.,	*Ventura*	37
Smylie, R. S.,	*San Diego*	22
Smyth, F. S.,	*San Francisco*	23
Smyth, M. H.,	*Stockton*	24
Smyth, R. J.,	*Cayucos*	25
Smythe, H.,	*Stockton*	24
Sneden, C. M.,	*Long Beach*	10
Snoddy, C. A.,	*Vallejo*	32
Snook, H. J.,	*Oakland*	1
Snow, H. L.,	*San Pedro*	10
Snow, W. F.,	*New York, N. Y.*	28
Snure, H.,	*Los Angeles*	10
Snyder, A. D.,	*Los Angeles*	10
Snyder, C. C.,	*Pasadena*	10
Snyder, G. A.,	*West Los Angeles*	10
Snyder, G. S.,	*San Francisco*	23
Snyder, W. H.,	*Hollywood*	10
Sobey, G. L.,	*Paso Robles*	25
Soderstrom, E. M.,	*Merced*	13
Sogemeier, E.,	*San Mateo*	26
Soghor, S.,	*Los Angeles*	10
Sohler, F. E.,	*Healdsburg*	33
Sohler, F. E., Jr.,	*Cloverdale*	33
Sofland, A.,	*Los Angeles*	10
Sokol, L. I.,	*Los Angeles*	10
*Solomon, J. C.,	*Los Angeles*	10
Solomon, W. O.,	*Oakland*	1
Somerfeld, E.,	*Los Angeles*	10
Somerfield, H. A.,	*San Francisco*	23
Somers, M. R.,	*San Francisco*	23
Sommer, E. A.,	*Chino*	21
Sonneland, S. G.,	*Los Angeles*	10
Sonnenberg, A.,	*San Francisco*	23
Sooy, D. W.,	*San Francisco*	23
Soper, H. V.,	*Los Angeles*	10
Soracco, C. V.,	*Placerville*	19
Sorauf, B. M.,	*Fresno*	4
Sorenson, E. J.,	*Hollywood*	10
Sornsen, A. A.,	*Los Angeles*	10
Sorsky, E. D.,	*Fresno*	4
Sosnowski, K. C.,	*Long Beach*	10
Soto-Hall, R.,	*San Francisco*	23
Soutar, R. G.,	*Sacramento*	19
Southgate, Paul T.,	*Long Beach*	10
Spalding, A. B.,	*San Francisco*	23
Spalding, C. A. H.,	*Richmond*	3
Spalding, J. B.,	*Richmond*	3
Spalding, R. B.,	*San Francisco*	23
Spaulding, A. Q.,	*Santa Barbara*	27
Spaulding, J. M.,	*Los Angeles*	10
Spear, E. B.,	*Los Angeles*	10
Spear, J. L.,	*Santa Rosa*	33
Speer, G. G.,	*Los Angeles*	10
Speik, F. A.,	*Los Angeles*	10
Spencer, G. A.,	*Sacramento*	19
Spencer, R. M.,	*Los Angeles*	10
Sperling, S.,	*Los Angeles*	10
Sperling, S. J.,	*Los Angeles*	10
Spiegel, M. J.,	*Los Angeles*	10
Spiers, H. W.,	*Los Angeles*	10
Spitalny, A.,	*San Francisco*	23
Sprague, B. H.,	*Los Angeles*	10
Sprague, G. T.,	*Van Nuys*	10
Sprauer, V. J.,	*Los Angeles*	10
Spruance, H. E.,	*San Diego*	22
Staatz, A. D.,	*Olive View*	10
Stabel, F.,	*Redding*	30
Stadfield, C. G.,	*Hollywood*	10
Stadler, E.,	*San Jose*	28
Stadlinger, K. P.,	*Burbank*	10
Stadtherr, E. F.,	*San Francisco*	23
Stadtmuller, E. S.,	*San Francisco*	23
Stafford, C. E.,	*Los Angeles*	10
Stafford, D. D.,	*Alameda*	1
Stafford, H. E.,	*Oakland*	1
Stafford, O. R.,	*Los Angeles*	10
Stahl, W. F.,	*Los Angeles*	10
Stailey, H. D.,	*Los Angeles*	10
Staniford, K. J.,	*Fresno*	4
Stanley, L. L.,	*San Rafael*	11
Stannard, A. N.,	*Berkeley*	1
Stanton, E. H.,	*Glendora*	10
Stanton, F. E.,	*Long Beach*	10
Stanton, R. H.,	*Pasadena*	10
Starbird, G. A.,	*King City*	14
Stark, B. W.,	*Tucson, Ariz.*	23
Stark, J. H.,	*Oakland*	1
Stark, M.,	*Los Angeles*	10
Starr, R. W.,	*Los Angeles*	10
Staub, J. S.,	*San Jose*	28
Stauffer, M. L.,	*Pittsburg*	3
Stealy, C. L.,	*San Diego*	22
Steddom, F. W.,	*Los Angeles*	10
Steele, A. A.,	*Los Angeles*	10
Steele, A. B.,	*Santa Barbara*	27
Steele, E. H.,	*Los Angeles*	10
Steele, J. T.,	*Dunsmuir*	31
Steele, M. T.,	*Los Angeles*	10
Steen, C. E.,	*Brea*	16
Steen, E. J.,	*Fullerton*	16
Steere, R. A.,	*Downey*	10
Steffy, J. L.,	*Santa Monica*	10
Stegeman, W.,	*Crescent City*	5
Stein, C.,	*Bellflower*	10
Stein, J. L.,	*Albany*	1
Stein, W. F.,	*Fresno*	4
Steinberg, J.,	*Los Angeles*	10
Steinert, G.,	*Isleton*	19
Steinmetz, A. F.,	*Hayward*	1
Steiss, C. F.,	*San Francisco*	23
Stelhorn, A. F.,	*Rosemead*	10
Stellar, R. W.,	*Wilmington*	10
Stephens, B. M.,	*Alameda*	1
Stephens, B. P.,	*Oakland*	1
Stephens, H. B.,	*San Francisco*	23
Stephens, J. S.,	*Los Angeles*	10
Stephens, P. H.,	*Los Angeles*	10
Stephens, W. B.,	*Alameda*	1
Stephens, W. C.,	*Pasadena*	10
Stephenson, H. A.,	*San Francisco*	23
Stern, R. G.,	*Los Angeles*	10
Stern, R. L.,	*Los Angeles*	10
Steven, R. A.,	*San Francisco*	23
Stevens, C. S.,	*Santa Barbara*	27
Stevens, G. A.,	*Los Angeles*	10
Stevens, G. M.,	*Los Angeles*	10
Stevens, J. B.,	*Los Angeles*	10
Stevens, W. E.,	*San Francisco*	23
Stevens, W. L.,	*Santa Monica*	10
Stevenson, A. P.,	*Torrance*	10
Stevenson, C. C.,	*Oakland*	1
Stevenson, G. L.,	*Sacramento*	19
Stevenson, G. R.,	*San Diego*	22
Stevenson, S. L.,	*San Francisco*	23
Stewart, A. E.,	*Los Angeles*	10
Stewart, H. B.,	*Modesto*	34
Stewart, H. J.,	*San Diego*	22
Stewart, S. F.,	*Los Angeles*	10
Stewart, W.,	*Los Angeles*	10
St. Geme, J. W.,	*Los Angeles*	10
Stibbens, F. H.,	*Oakland*	1
Stickler, J. H.,	*Flintridge, Pasadena*	10
Stiles, F. E.,	*San Francisco*	23
Stilson, G. D.,	*Long Beach*	10
Stilson, W. L.,	*Los Angeles*	10
Stilwell, L. E.,	*Hollywood*	10
Stimson, C. A.,	*Petaluma*	33
Stirewalt, H. W.,	*Concord*	3
Stockton, A. B.,	*San Francisco*	23
Stoddard, J. McC.,	*Beverly Hills*	10
Stoddard, T. A.,	*San Francisco*	23
Stoker, E. M.,	*San Francisco*	23
Stoll, A. H.,	*Oxnard*	37
Stolle, F.,	*Dixon*	32
Stolz, C. E.,	*Los Angeles*	10
Stolz, H. R.,	*Berkeley*	1
Stone, B.,	*San Francisco*	23
Stone, B. L.,	*San Diego*	22
Stone, C. S.,	*Santa Barbara*	27
Stone, E. M.,	*Oceanside*	22
Stone, R. S.,	*San Francisco*	23
Stone, W. J.,	*Pasadena*	10
Stookey, L. J.,	*San Francisco*	23
Stoops, R. P.,	*Oakland*	1
Storey, T. A.,	*Stanford University*	28
Stork, V. E.,	*Los Angeles*	10
Stoughton, A. V.,	*Claremont*	10
Stout, G. T.,	*Los Angeles*	10
Stout, K. L.,	*Sacramento*	4
Stovall, L.,	*Los Angeles*	10
Stowe, O. P.,	*Oakland*	1
Stowe, W. P.,	*San Francisco*	23
Strahlmann, L.,	*San Diego*	22
Strange, S. P.,	*San Francisco*	23
Strange, V. M.,	*San Francisco*	23
Stratford, E. B.,	*Los Angeles*	10
Strathearn, H. J.,	*Hollywood*	10
Stratton, E. K.,	*San Francisco*	23
Stratton, G. W.,	*Marysville*	39
Stratton, J. M.,	*Berkeley*	1
Strauss, B.,	*San Francisco*	23
Streaker, L. H.,	*Goleta*	27
Street, L. A. B.,	*Los Angeles*	10
Strickler, D.,	*San Francisco*	23
Strickler, J. P.,	*San Francisco*	23
Striegel, L. McC.,	*Long Beach*	10
Strietmann, W. H.,	*Oakland*	1
Strong, A. J.,	*Santa Paula*	37
Strongin, S.,	*Bakersfield*	7
Strouse, S.,	*Los Angeles*	10
Struble, H. P.,	*Hayward*	1
St. Sure, F. A.,	*San Diego*	22
Stump, F. M.,	*Crescent City*	5
Sturdivant, B. F.,	*Pasadena*	10
Sturgeon, C. T.,	*Los Angeles*	10
Sturges, R. L.,	*Los Angeles*	10
*Styan, W. E.,	*San Francisco*	26
Sudlow, E. L.,	*San Fernando*	10
Suehs, P. E.,	*San Francisco*	23
Sugar, H.,	*Los Angeles*	10
Suglian, V. V.,	*San Francisco*	23
Sullivan, C. S.,	*San Jose*	28
Sullivan, J. J.,	*Oakland*	1
Sullivan, J. M.,	*San Francisco*	23
Sullivan, J. R.,	*San Francisco*	23
Sullivan, N. R.,	*Santa Cruz*	29
Sullivan, W.,	*Ahwahnee*	23
Sullivan, W. A.,	*Ontario*	21
Sullivan, W. J.,	*Hollywood*	10
Sulzbacher, C. I.,	*Los Angeles*	10
Sumerlin, H. S.,	*San Diego*	22
Sundberg, R. H.,	*San Diego*	22
Sundin, P. O.,	*Los Angeles*	10
Sunzeri, A. T.,	*San Jose*	28
Suski, P. M.,	*Los Angeles*	10
Susnow, D. A.,	*San Francisco*	23
Sutherland, K. H.,	*Santa Ana*	16
Sutherland, P. R.,	*Los Angeles*	10
Sutherland, R. T.,	*Oakland*	1
Sutherlin, C. G.,	*Los Angeles*	10
Sutton, T. L.,	*Stockton*	24
Svoboda, F. C.,	*San Diego*	22
Swanson, C. F.,	*Los Angeles*	10
Swarts, R. E.,	*Hartford, Conn.*	26
Swauger, L. S.,	*Oakland*	1
Swearingen, F. C.,	*Pomona*	10
Sweeney, A. H.,	*Fresno*	4
Sweeney, J. P.,	*Milbrae*	26
Sweet, C. D.,	*Oakland*	1
*Sweet, E.,	*Los Angeles*	10
*Sweet, F. D.,	*Long Beach*	10
Sweetser, G. W.,	*Martinez*	3
Swengel, W. F.,	*Monterey*	14
Swenson, R. T.,	*Van Nuys*	10
Swett, W. F.,	*San Francisco*	23
Swezey, S.,	*Los Angeles*	10
Swift, L. M.,	*Marysville*	39
Swigart, M.,	*Monterey*	14
Swim, W. A.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Swindt, J. M.,	*Chino*	21
Swinney, R. W.,	*Long Beach*	10
Syer, W. H.,	*Los Angeles*	10
Syman, L. W.,	*Los Angeles*	10
Symonds, C. W.,	*Pasadena*	10
Szukalski, J. P.,	*Pasadena*	10

— T —

Taber, K. W.,	*Pasadena*	10
Taber, L. E.,	*San Francisco*	23
Tager, B. N.,	*West Los Angetes*	10
Taggart, M. M.,	*McFarland*	7
Talbott, E. M.,	*San Francisco*	23
Talbott, G. M.,	*San Francisco*	23
Talmage, C. H.,	*Sanitarium*	15
Taltavall, W. A.,	*Redlands*	21
Tandowsky, R. M.,	*Hollywood*	10
Tanaka, R. K.,	*San Diego*	22
Tanner, C. O.,	*San Diego*	22
Tarnutzer, B. C.,	*Los Angeles*	10
Tarr, E. M.,	*Los Angeles*	10
Tatro, R. F.,	*San Bernardino*	21
Tattersall, K. L.,	*Oakland*	1
Taubles, G. H.,	*San Francisco*	23
Taussig, L.,	*San Francisco*	23
Taylor, D. A.,	*San Francisco*	23
Taylor, E. C.,	*San Francisco*	23
Taylor, E. M.,	*Oakland*	1
Taylor, F. B.,	*Oakland*	1
Taylor, F. W. H.,	*Los Angeles*	10
Taylor, G. M.,	*Los Angeles*	10
Taylor, L. E.,	*Los Angeles*	10
Taylor, L. H.,	*Oakland*	1
Taylor, L. M.,	*San Bernardino*	16
Taylor, P. A.,	*San Francisco*	23
Taylor, R. G.,	*Los Angeles*	10
Taylor, R. N.,	*Long Beach*	10
Taylor, R. O.,	*San Diego*	22
Taylor, R. T.,	*Los Angeles*	10
Taylor, W.,	*Martinez*	3
Teaby, W. L.,	*Monterey*	14
Teall, R. C.,	*Sacramento*	19
Teass, C. J.,	*San Luis Obispo*	25
Tebbe, F. H.,	*Oakland*	1
Tebbetts, H. B.,	*Los Angeles*	10
Tebbetts, H. E.,	*Whittier*	10
Tedstrom, M. K.,	*Santa Ana*	16
Teel, A. W.,	*Los Angeles*	10
Teeter, A. L.,	*Oakland*	1
Teitler, M. H.,	*San Francisco*	23
Temple, R. J.,	*Los Angeles*	10
Templeton, H. J.,	*Oakland*	1
Templeton, W. K.,	*Riverside*	18
Tepper, G. B.,	*Los Angeles*	10
Terrill, E. E.,	*Los Angeles*	10
Terry, R. A.,	*Long Beach*	10
Terry, W. I.,	*San Francisco*	23
Thayer, L. E.,	*Los Angeles*	10
Thebaut, W. M., Jr.,	*Oakland*	1
Thelander, H. E.,	*San Francisco*	23
Thelen, E.,	*San Diego*	22
Thibodeau, J. A.,	*San Francisco*	23
Thienes, C. H.,	*Los Angetes*	10
Tholen, E. F.,	*Los Angeles*	10
Thomas, B.,	*Oakland*	1
Thomas, B. S.,	*Sacramento*	19
Thomas, E. W.,	*San Bernardino*	30
Thomas, G. F.,	*Los Angetes*	10
Thomas, R. E.,	*Los Angeles*	10
Thomas, V. E.,	*Pasadena*	10
Thomas, W. C.,	*Long Beach*	10
Thomas, W. McL.,	*San Diego*	22
Thomason, G.,	*Los Angeles*	10
Thomason, S. D.,	*San Dimas*	10
Thompson, A. C.,	*Mountain View*	28
Thompson, A. R.,	*Rio Vista*	32
Thompson, C. P.,	*San Francisco*	23
Thompson, C. V.,	*Pescadero*	26
Thompson, C. V.,	*Lodi*	24
Thompson, C. W.,	*Pasadena*	10
Thompson, D. E.,	*Red Bluff*	35
Thompson, E. E.,	*Red Bluff*	35
Thompson, E. H.,	*Burbank*	10
Thompson, H. A.,	*San Diego*	21
Thompson, H. D.,	*Los Angeles*	10
Thompson, H. F.,	*Los Angeles*	10
Thompson, H. L.,	*Los Angeles*	10
Thompson, H. L.,	*Long Beach*	10
Thompson, I. B.,	*Sonora*	24
Thompson, J. E.,	*Los Angeles*	10
Thompson, K. J.,	*Oakland*	1
Thompson, L. R.,	*San Pedro*	10
Thompson, O. E.,	*Los Angetes*	18
Thompson, R. C.,	*Whittier*	10
Thompson, R. H.,	*Los Angetes*	10
Thompson, R. J.,	*Los Angeles*	10
Thompson, R. L.,	*Burbank*	10
Thompson, V. P.,	*Los Angeles*	10
Thompson, W. B.,	*Los Angeles*	10
Thomson, A. M.,	*Santa Rosa*	33
Thomson, D.,	*Burbank*	10
Thomson, H. S.,	*San Francisco*	23
Thomson, R. R.,	*Oakland*	1
Thomson, W. L.,	*San Francisco*	23
Thoren, M. E.,	*Weimar*	17
Thorne, I. W.,	*San Francisco*	23
Thorner, M.,	*Santa Maria*	24
Thornton, A. J.,	*San Diego*	22
Thornton, J.,	*Los Angeles*	10
Thorpe, A. C.,	*Los Angeles*	10
Thorpe, F.,	*Hollywood*	10
Threlfall, D. R.,	*San Jose*	28
Thunen, P. E.,	*Marysville*	39
Thurber, F.,	*Hollywood*	10
Thurber, P.,	*Los Angeles*	10
Thuresson, P. F.,	*Riverside*	18
Thurlow, A. A.,	*Santa Rosa*	33
Thurlow, J. F.,	*Santa Rosa*	33
Tiber, L. J.,	*Los Angeles*	10
Tice, E. W.,	*Los Angeles*	10
Tickell, A. H.,	*Nevada City*	17
Tiffany, D. F. E.,	*San Jose*	28
Tillman, F. J.,	*Fresno*	4
Tillman, T. E.,	*San Francisco*	23
Tillmanns, C. S. J.,	*Los Angetes*	10
Tillotson, J. E.,	*Colusa*	38
Tillotson, R. S.,	*Sacramento*	19
Timme, A. R.,	*Los Angeles*	10
Timon, A. N.,	*Los Angeles*	10
Tipton, S. P.,	*Watsonville*	29
Tisinger, E. L.,	*San Bernardino*	21
Titcomb, L. R.,	*Los Angeles*	10
Titus, C. I.,	*Sacramento*	19
Titus, J. H.,	*Ontario*	21
Tobias, E. B.,	*San Francisco*	23
Tobias, M.,	*Los Angeles*	10
Tobin, P. A.,	*San Francisco*	23
Tock, E. W.,	*Santa Ana*	16
Todd, J. B.,	*Los Angetes*	10
Toffelmier, D. D.,	*Oakland*	1
Togasaki, K.,	*San Francisco*	23
Togasaki, T.,	*San Francisco*	23
Toland, C. G.,	*Los Angeles*	10
Tollefson, D. G.,	*Los Angeles*	10
Toller, R. B.,	*Talmage*	12
Tolman, G. P.,	*Watsonville*	29
Tomblin, B. M. A.,	*Los Angetes*	10
*Tomlinson, R. F.,	*San Francisco*	23
Toomey, F. E.,	*San Diego*	22
Topham, E.,	*San Francisco*	23
Topping, F. P.,	*Carmel*	14
Torbert, H. C.,	*San Diego*	22
Torell, G. J.,	*Los Angeles*	10
Torrano, M. A.,	*Oakland*	1
Torre, E. D.,	*San Francisco*	23
Torrens, A. S.,	*Hanford*	8
Torrey, F. A.,	*San Francisco*	23
Torrey, H. B.,	*Stanford University*	28
Totten, H. P.,	*Los Angetes*	10
Tourtillot, W. W.,	*Porterville*	36
Towne, E. B.,	*San Francisco*	23
Townsend, C. E.,	*Alhambra*	10
Townsend, K.,	*Los Angeles*	10
Traber, C. H.,	*Reedley*	4
Trainor, J. V.,	*Los Angeles*	10
Trainor, M. E.,	*Los Angeles*	10
Trauner, L. M.,	*San Francisco*	23
Traver, C. M.,	*Patton*	21
Trelstad, B. L.,	*Redding*	30
Tretheway, L. E.,	*Manteca*	24
Treweek, D. N.,	*Los Angeles*	10
Trick, T. R.,	*Stockton*	24
Trimble, H. G.,	*Oakland*	1
Trimmer, E. L.,	*Los Angeles*	10
Trott, L. d'N.,	*Santa Ana*	16
Trotter, A. D.,	*Los Angeles*	10
Troup, R. M.,	*Berkeley*	1
*Trowbridge, D. H.,	*Fresno*	4
Trowbridge, D. H., Jr.,	*Fresno*	4
Truax, J. P.,	*Lompoc*	27
True, H. F.,	*Sacramento*	19
Truman, S. R.,	*Oakland*	1
Truxaw, J. W.,	*Anaheim*	16
Tucker, G. E.,	*Manhattan Beach*	10
Tucker, H.,	*Agnew*	28
Tucker, M. B.,	*Oakland*	1
Tucker, M. O.,	*Ocean Park*	10
Tucker, R. G.,	*Alhambra*	10
Tulley, F. E.,	*Jamut*	22
Tully, J. J.,	*Stockton*	24
Tunnell, A. M.,	*Lodi*	24
Tupper, R. B.,	*Fresno*	4
Turbow, A. O.,	*Los Angeles*	10
Turco, E. A.,	*San Jose*	28
Turkel, A. S.,	*Los Angeles*	10
Turley, J. G.,	*Los Angeles*	10
Turnbull, F. M.,	*Los Angeles*	10
Turner, E. C.,	*Sacramento*	19
Turner, E. L.,	*Los Angeles*	10
Turner, J. H.,	*Huntington Park*	10
Tuteur, E. B.,	*Los Angeles*	10
Tuttle, A. D.,	*No. Little Rock, Ark.*	22
Tuttle, S.,	*San Francisco*	23
Twitchell, E. W.,	*San Francisco*	23
Tyler, L. G.,	*San Rafael*	11
Tyler, Y. C.,	*Berkeley*	1
Tyroler, F. N.,	*Los Angetes*	10

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Uhls, R. T.,	*Long Beach*	10
Ullmann, H. J.,	*Santa Barbara*	27
Ullrich, F. D.,	*Hemet*	18
Unsinger, H. F.,	*San Francisco*	23
Updegraff, H. L.,	*Hollywood*	10
Up de Graff, T. S.,	*Pasadena*	10
Upshaw, H. T.,	*Pasadena*	10
Upton, J. R.,	*San Francisco*	23
Ussher, N. T.,	*Santa Barbara*	27
Utter, J. W.,	*Anaheim*	16
Uyeyama, H.,	*Oakland*	1
Uyeyama, K.,	*San Francisco*	23

— V —

Vachout, M. A.,	*Southgate*	10
Vallee, J. E.,	*Los Angeles*	10
Van Allen, L. K.,	*Ukiah*	12
Vance, H. W.,	*Pasadena*	10
Vance, J. T.,	*Sacramento*	19
Van Cott, W. B.,	*Los Angeles*	10
Van Dalsem, S. B.,	*San Jose*	28
Van Dalsem, W. S.,	*San Jose*	28
Van Den Berg, W. J.,	*Sacramento*	19
Van de Carr, F. R.,	*Oakland*	1
Vanderburgh, C. M.,	*Fresno*	4
Van de Pol, A.,	*Modesto*	34
Van der Leek, P.,	*Stockton*	24
Van Deventer, W. C.,	*Redwood City*	23
Vandevert, G. V.,	*Oakland*	1
Van Doren, B. J.,	*Laguna Beach*	16
Van Dyke, H. M.,	*Long Beach*	10
Van Eman, O. H.,	*El Centro*	6
Van Fleet, H. D.,	*Los Angeles*	10
Van Meter, A. L.,	*Stockton*	24
Van Meter, F. J.,	*Norwalk*	10
Van Nuys, R. G.,	*Berkeley*	1
Van Ornum, E. N.,	*Los Angeles*	10
Van Paing, J. F.,	*Santa Barbara*	27
Van Pelt, R. S.,	*Los Angeles*	10
Van Sciver, C. B.,	*Los Angeles*	10
Van Scoyoc, J. G.,	*Los Angeles*	10
*Van Sickle, J. R.,	*Santa Monica*	10
Van Soest, E. H.,	*Los Angeles*	10
Van Vorhis, J. H.,	*Corcoran*	8
Van Wagenen, R. J.,	*Fresno*	4
Van Wart, R. M.,	*West Los Angetes*	10
Varden, A. E.,	*San Bernardino*	21
Vardon, C. C.,	*Oakland*	1
Vardon, E. M.,	*Los Angeles*	10
Vargas, R. A.,	*San Bernardino*	21
Vaughan, L. B.,	*Long Beach*	10
Vaughn, J. O.,	*Santa Monica*	10
Vecki, M. E.,	*San Francisco*	23
Venzke, H.,	*Pasadena*	10
Veon, J. E.,	*Bakersfield*	7
Verbryck, G. G.,	*Long Beach*	10
Verne, V. E.,	*Long Beach*	10
Viau, B. H.,	*Sanger*	4
Vickerson, J. I.,	*Oakland*	1
Vidgoff, I. J.,	*Los Angeles*	10
Vidrickson, H. L.,	*Weed*	31
Viecelli, J. D.,	*San Francisco*	23
Vieira, E.,	*Sebastopol*	33
Vieira, F. G.,	*Stockton*	24
Vinetz, J. C.,	*Los Angeles*	10
Vinks, W. A.,	*Lincoln*	17
Viole, P. P.,	*Los Angeles*	10
Violett, C. C.,	*Garden Grove*	16
Visalli, J.,	*San Francisco*	23
Visscher, L. G.,	*Los Angeles*	10
Vizzard, W. R.,	*San Francisco*	23
Vogelman, J.,	*San Jose*	28
Voight, C. E.,	*San Francisco*	23
Vollert, A. J.,	*San Francisco*	23
Vollmer, A. M.,	*San Francisco*	23
Vollmer, H. W.,	*Sanitarium*	15
von Briesen, H.,	*Los Angeles*	10
Von der Lieth, H. O.,	*San Francisco*	23
von Geldern, C. E.,	*Sacramento*	19
von Geldern, H.,	*San Francisco*	23
Von Hagen, K. O.,	*Los Angeles*	10
von Wedelstaedt, B.,	*Long Beach*	10
Voorhees, H. M.,	*Los Angeles*	10
Voorsanger, W. C.,	*San Francisco*	23
Vruwink, J.,	*Los Angeles*	10

— W —

Waddell, D. Q.,	*Los Angeles*	10
Waddell, W. E.,	*Los Angeles*	10
Wade, A. B.,	*Santa Ana*	16
*Wade, L. T.,	*San Luis Obispo*	25
Wade, R. S.,	*Santa Ana*	16
Wagner, A. F.,	*Los Angeles*	10
Wagner, L. D.,	*Pasadena*	10

NAME	CITY	COUNTY SOCIETY NO.
Wagner, R. J.,	*San Francisco*	23
Wagner, V. E.,	*San Dimas*	10
Wahl, H. A.,	*San Francisco*	23
Wahle, H.,	*Oakland*	1
Wahlen, J. A.,	*Montebello*	10
Wahrhaftig, M. J.,	*Fresno*	4
Waltzfelder, F.,	*Los Angeles*	10
Wakefield, R. F.,	*Pasadena*	10
Wald, H. A.,	*So. San Francisco*	23
Wales, J. LeR.,	*Long Beach*	10
Walker, A. W.,	*Riverside*	18
Walker, B. F.,	*Fresno*	4
Walker, C. A.,	*San Francisco*	23
Walker, C. B.,	*Los Angeles*	10
Walker, G. W.,	*Fresno*	4
Walker, H. M.,	*Los Angeles*	10
Walker, J. D.,	*Los Angeles*	10
Walker, J. E.,	*Long Beach*	10
Walker, J. R.,	*Fresno*	4
Walker, P. J.,	*Los Angeles*	10
Walker, R. A.,	*Alhambra*	10
Walker, R. J.,	*Oakland*	1
Walker, R. S.,	*Oakland*	1
Walker, W. H.,	*Willows*	38
Wall, H. W.,	*Hollywood*	10
Wall, M. M.,	*San Francisco*	23
Wallace, A.,	*Los Angeles*	10
Wallace, C. T.,	*Eureka*	5
Wallace, E. P.,	*Los Angeles*	10
Wallace, J. A.,	*Calipatria*	6
Wallace, W. E.,	*Whittier*	10
Wallace, W. S.,	*Orange*	16
Wallach, I. A.,	*Los Angeles*	10
Wallentine, N. R.,	*Long Beach*	10
Waller, L. M.,	*Hollywood*	10
Wallerius, R. M.,	*Sacramento*	19
Walrath, G. B.,	*Los Angeles*	10
Walsh, F. D.,	*Oakland*	1
Walsh, J. F.,	*Eureka*	5
Walter, F. J.,	*San Diego*	22
Walters, C. M. C.,	*Los Angeles*	10
Walters, H. S.,	*San Luis Obispo*	25
Walters, P. R.,	*Berkeley*	1
Walton, G. E.,	*Oakland*	1
Walton, H. M.,	*Takoma Park, Md.*	21
Walton, R. R.,	*Linwood*	10
Warburton, J. A.,	*Burlingame*	26
Ward, R.,	*San Francisco*	23
Wardrip, B. H.,	*San Jose*	28
Ware, E. R.,	*Los Angeles*	10
Ware, J. G.,	*Bakersfield*	27
Wargin, J. I.,	*Los Angeles*	10
Warmer, C. A.,	*Los Angeles*	10
Warner, H. E.,	*Los Angeles*	10
Warner, O. H.,	*San Diego*	22
Warnock, A. W.,	*San Pedro*	10
Warnshuis, F. C.,	*San Francisco*	23
Warren, H. C.,	*Belmont*	26
Warren, J. P.,	*San Francisco*	23
Warren, J. W.,	*Los Angeles*	10
Warren, J. W.,	*National City*	22
Washburn, W. W.,	*San Francisco*	23
Watanabe, L. M.,	*San Jose*	28
Waters, M. A.,	*Woodland*	38
Waters, P. S.,	*Patton*	21
Waters, Z. O.,	*San Francisco*	23
Watke, L. E.,	*Tulare*	36
Watkins, L. H.,	*Pasadena*	10
Watkins, W. E.,	*Santa Ana*	16
Watson, A. R.,	*Eureka*	5
Watson, F. R.,	*San Mateo*	26
Watson, F. V.,	*Hollywood*	10
Watson, H. G.,	*San Francisco*	23
Watson, L. F.,	*Los Angeles*	10
Watson, R. G.,	*Oakland*	1
Watson, T.,	*Sunnyvale*	28
Watters, E. M.,	*Santa Cruz*	29
Watters, H. G.,	*Watsonville*	29
Waxman, A.,	*Los Angeles*	10
Way, S. C.,	*San Francisco*	23
Wayburn, E.,	*San Francisco*	23
Wayland, C.,	*San Jose*	28
Wayland, R. T.,	*Glendale*	10
Wayte, E. W.,	*Norwalk*	10
Weaver, C. H.,	*Los Angeles*	10
Weaver, D. D.,	*Oakland*	1
Webber, W. T.,	*Long Beach*	10
Weber, A. L.,	*Upland*	21
Weber, W. L.,	*Los Angeles*	10
Webster, D. P.,	*Fresno*	4
Webster, G. M.,	*Patton*	21
Webster, J. C.,	*Los Angeles*	10
Webster, J. S.,	*Mariposa*	13
*Webster, O. L.,	*Holtville*	6
Wedgewood, P. E.,	*San Diego*	22
Weeks, A.,	*San Francisco*	23
Weeks, C. L.,	*Los Angeles*	10
Wehrly, J.,	*Santa Ana*	16
Wehrly, W. S.,	*Santa Ana*	16
Weil, S. N.,	*Rodeo*	3
Weinberg, S. J.,	*West Los Angeles*	10
Weinberg, S. L.,	*Los Angeles*	10
Weinberger, J.,	*San Diego*	22
Weiner, W. M.,	*San Francisco*	23
Weiser, A. D.,	*Los Angeles*	10
Weiskotten, W. O.,	*San Diego*	22
Weiss, K. F.,	*Visalia*	36
Weitkamp, A. H.,	*Los Angeles*	10
Welbourn, L. S.,	*Van Nuys*	10
Welbourn, M. A.,	*Los Angeles*	10
Welbourn, P. M.,	*Los Angeles*	10
Welch, E. H.,	*Pomona*	10
Welch, S. H.,	*Glendale*	10
Welcome, E. H.,	*Downey*	10
Welfer, C. R.,	*Los Angeles*	10
Weller, T. W.,	*Oakland*	1
Wellman, O. F.,	*San Pedro*	10
Wells, C. E.,	*Woodlake*	36
Wells, E. W.,	*Los Angeles*	10
Wells, G. D.,	*Los Angeles*	10
Wells, J. T.,	*San Diego*	22
Wells, M. C.,	*Los Angeles*	10
Wells, P. H.,	*Arcadia*	15
Wells, S. J.,	*Sacramento*	19
Welpton, M. A.,	*San Diego*	22
Welsh, O. A.,	*Ventura*	37
Welti, L.,	*Napa*	15
Wemple, E. L.,	*Verdugo City*	10
Werden, D. H.,	*San Diego*	22
Werlich, R. E.,	*San Diego*	22
Werner, E. A.,	*Los Angeles*	10
Werthmann, P. A.,	*Gustine*	24
Weseman, R. J.,	*Novato*	11
Wessels, A. L.,	*Salinas*	14
Wessels, W. F.,	*Los Angeles*	10
Wessly, W. D.,	*Glendale*	10
Wesson, M. B.,	*San Francisco*	23
West, F. D.,	*Beaumont*	18
West, H. F.,	*Los Angeles*	10
West, J. H.,	*San Francisco*	23
Westerhout, C. E.,	*Brea*	16
Weston, F. P.,	*Pasadena*	10
Weston, F. W.,	*Tustin*	16
Westphal, H. G.,	*Glendale*	10
Wetherill, G. G.,	*San Diego*	22
Wetmore, C. T.,	*Berkeley*	1
Wever, G. K.,	*Stockton*	24
Whalen, J. F.,	*Altadena*	10
Whalen, T. J.,	*San Francisco*	23
Whalman, H. F.,	*Los Angeles*	10
Wharton, C. G.,	*Los Angeles*	10
Wheatley, W. G.,	*Azusa*	10
Wheeler, H. D.,	*Inglewood*	10
Wheeler, O. W.,	Riverside	18
Wheelis, J. M.,	*Beverly Hills*	10
Whitaker, L. S.,	*San Jose*	28
Whitcomb, E. L.,	*Los Angeles*	10
White, A. S.,	*San Francisco*	23
White, H. L.,	*Redding*	30
White, J. F.,	*San Diego*	22
White, J. H.,	*Chico*	2
White, L. F.,	*Los Angeles*	10
White, M. D.,	*Ontario*	21
White, P. G.,	*Los Angeles*	10
Whitecotton, G. O.,	*San Francisco*	23
Whitelock, T. S.,	*San Diego*	22
Whitelock, T. S., Jr.,	*San Diego*	22
Whiting, E. G.,	*Berkeley*	1
Whiting, F. M.,	*Oroville*	2
Whitlow, J. E.,	*Fillmore*	10
Whitmer, C. F.,	*Colton*	21
Whitney, H. H.,	*Burlingame*	26
Whitney, R. B.,	*Yuba City*	39
Whitsett, J. W.,	*Los Angeles*	10
Whittaker, L. F.,	*Huntington Beach*	16
Wickman, H. J.,	*Riverside*	18
Wiebe, D.,	*Reedley*	4
Wiebe, F. E.,	*Salinas*	14
Wiebusch, E. G. L.,	*Los Angeles*	10
Wiel, H. I.,	*San Francisco*	23
Wieman, W. H.,	*Los Angeles*	10
Wiens, F. L.,	*Porterville*	36
Wiese, W. F.,	*Fresno*	4
Wightman, A. H.,	*Laguna Beach*	16
Wilbur, B. C.,	*Palo Alto*	28
Wilbur, R. L.,	*Stanford University*	23
Wilcox, A. B.,	*Santa Barbara*	27
Wilcox, C. F.,	*Huntington Park*	10
Wilcox, M. R.,	*Los Angeles*	10
Wilcox, R. W.,	*Long Beach*	10
Wilder, E. M.,	*Sacramento*	19
Wiley, E. H.,	*Los Angeles*	10
Wiley, H. J.,	*Huntington Park*	10
Wilhelm, L. F. X.,	*Los Angeles*	10
Wilhoit, J. W.,	*Ocean Beach*	22
Wilke, J. O.,	*Hermosa Beach*	10
Wilken, H. T.,	*Santa Monica*	10
Wilkinson, A. J.,	*National City*	22
Wilkinson, A. M.,	*Hollywood*	10
Willard, W. P.,	*San Francisco*	23
Willcutt, G. H.,	*San Rafael*	11
Willems, L. C.,	*Glendale*	10
Williams, A. H.,	*Hollywood*	26
Williams, A. J.,	*San Francisco*	23
Williams, A. W.,	*Los Angeles*	10
Williams, C. G.,	*Santa Monica*	10
Williams, D. B.,	*Colton*	21
Williams, D. B.,	*Veterans Home*	15
Williams, E. H.,	*Los Angeles*	10
Williams, F.,	*San Francisco*	23
Williams, F. F., Jr.,	*Patton*	21
Williams, J.,	*Eldridge*	33
Williams, J. B.,	*Los Angeles*	10
Williams, J. C.,	*San Francisco*	23
Williams, N. H.,	*Los Angeles*	10
Williams, P. M.,	*Los Angeles*	10
Williams, R.,	*Los Angeles*	10
Williams, W. F.,	*Oakland*	1
Williamson, M. A.,	*Oceanside*	7
Williamson, M. C.,	*Upland*	21
Williamson, N. E.,	*Stockton*	24
Williamson, R. G.,	*Ontario*	21
Willifer, A. F.,	*San Diego*	22
Willis, H. Q.,	*Balboa*	16
Willits, E. K.,	*San Francisco*	23
Wills, C. A.,	*Oakland*	1
Wills, I.,	*Santa Barbara*	27
Willson, L. R.,	*Fresno*	4
Wilmar, A. H.,	*Paso Robles*	25
Wilmes, M. N.,	*Redding*	30
Wilson, C.,	*Los Angeles*	10
Wilson, C. A.,	*Los Angeles*	10
Wilson, C. G.,	*Palo Alto*	28
Wilson, D. R.,	*San Jose*	28
Wilson, G.,	*Sacramento*	19
Wilson, G. W.,	*Los Angeles*	10
Wilson, H. F.,	*San Francisco*	23
Wilson, H. H.,	*Los Angeles*	10
Wilson, H. P.,	*Whittier*	10
Wilson, H. R.,	*Modesto*	34
Wilson, H. S.,	*N. Hollywood*	10
Wilson, J. B.,	*San Francisco*	23
Wilson, J. C.,	*San Jose*	28
Wilson, J. C.,	*Los Angeles*	10
Wilson, J. D.,	*Berkeley*	1
Wilson, J. M.,	*Pasadena*	10
Wilson, J. W.,	*San Francisco*	23
Wilson, J. W., Jr.,	*Los Angeles*	10
Wilson, L. E.,	*Anaheim*	16
Wilson, K. R.,	*Santa Barbara*	27
Wilson, R. D.,	*Los Angeles*	10
Wilson, W. M.,	*Weaverville*	30
Wimmer, S. D.,	*Los Angeles*	10
Wimp, W. H.,	*Laguna Beach*	16
Wind, E.,	*Hollywood*	10
Wineberg, A. C.,	*Oakland*	1
Wineland, A. J.,	*Los Angeles*	10
Wing, L. A.,	*Eureka*	5
Winn, W. A.,	*Springville*	36
Winnard, W. F. R.,	*Los Angeles*	10
Winslow, A. L.,	*Oakland*	1
Winter, W. G.,	*Olive View*	10
Winterberg, W. H.,	*San Francisco*	23
Winternitz, C. D.,	*San Francisco*	23
Winters, W. P.,	*San Diego*	22
Wiper, T. B.,	*San Francisco*	23
Wirt, S. K.,	*Sunnyvale*	10
Wirth, R. G.,	*La Verne*	10
Wise, D. C.,	*Pittsburg*	3
Wise, P. L.,	*San Jose*	28
Wisner, F. B.,	*Marysville*	39
Wissner, L. O.,	*Modesto*	34
Witherbee, H. R.,	*Los Angeles*	10
Witter, C. B.,	*Los Angeles*	10
Wold, A. P.,	*Oakland*	1
Wolf, G. L.,	*San Francisco*	23
Wolfe, H. H.,	*Fort Bragg*	12
Wolff, E.,	*San Francisco*	23
Wolff, F. S.,	*San Francisco*	23
Wolff, M. J.,	*Los Angeles*	10
Wolfsen, L. H.,	*Modesto*	34
Wolfsohn, J. M.,	*San Francisco*	23
Wolfsohn, M.,	*Monterey*	14
Wolfson, I. E.,	*Los Angeles*	10
Wood, C. H.,	*Glendora*	10
Wood, C. L.,	*St. Helena*	15
Wood, D. A.,	*San Francisco*	23
Wood, D. A.,	*San Francisco*	23
Wood, F. W.,	*Alhambra*	10
Wood, G. J.,	*St. Helena*	15
Wood, G. N., Jr.,	*Palo Alto*	28
Wood, H. A.,	*Beaumont*	18
Wood, J. A.,	*Anaheim*	16
Wood, L. D.,	Banning	18
Wood, O. T.,	*Red Bluff*	35
Wood, R. F.,	*National City*	22
Wood, W. A.,	*Oakland*	1
Woodard, D. S.,	*Watsonville*	29
Woodhull, C. G.,	*Los Angeles*	10
Woodhull, R. A.,	*Los Angeles*	10
Woods, D. L.,	*Los Angeles*	10
Woods, L.,	*Oakland*	1
Woods, N. C.,	*Alhambra*	10
Woods, R. A.,	*Los Angeles*	10
Woolf, M. S.,	*San Francisco*	23
Woolfan, E. B.,	*Los Angeles*	10
Woolford, J. S.,	*Eureka*	5
Woolsey, C. H.,	*San Francisco*	23
Woolsey, J. H.,	*Woodland*	38
Woolston, W. J.,	*Pasadena*	10
Workman, R. A.,	*Pacific Grove*	14
Worster, W. W.,	*San Gabriel*	10
Worthington, L. C.,	*Bakersfield*	7
Worthington, R. L.,	*San Diego*	22
Wright, B. W.,	*Los Angeles*	10
Wright, C. A.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Wright, J. M.,	*Pasadena*	10
Wright, K. D.,	*Venice*	10
Wright, La V.,	*San Francisco*	23
Wright, R. W.,	*Palo Alto*	28
Wright, W. B., Jr.,	*Long Beach*	10
Wright, W. M.,	*Los Angeles*	10
Wrigley, G. C.,	*Sonora*	24
Wrinkle, G. S.,	*Talmage*	12
Wyckoff, H. A.,	*San Francisco*	23
Wyers, R. E.,	*Spadra*	10
Wylie, C. A.,	*San Bernardino*	21
Wynns, H. LeR.,	*Berkeley*	1

— Y —

Yabroff, S. W.,	*Oakland*	1
Yaker, D. N.,	*Los Angeles*	10
Yamao, E.,	*Walnut Grove*	19
Yant, J. H.,	*Sacramento*	19
Yates, J. E.,	*Sacramento*	19
Yeagle, R. P.,	*Santa Ana*	16
Yerxa, C. W.,	*Los Angeles*	10
Yoakam, F. A.,	*Moorpark*	37
Yocom, F. W.,	*San Luis Obispo*	34
Yoder, E. H.,	*Los Angeles*	10
Yoell, R. A.,	*San Francisco*	23
Yost, F. O.,	*Los Angeles*	10
Young, B. A.,	*Long Beach*	10
Young, C. S.,	*Los Angeles*	10
Young, D. D.,	*Los Angeles*	10
Young, E. L.,	*San Diego*	22
Young, E. N.,	*San Diego*	22
Young, F. B.,	*Long Beach*	10
Young, H. M.,	*San Diego*	22
Young, J. H.,	*San Diego*	22
Young, J. P.,	*Lemoore*	8
Young, J. W.,	*Beverly Hills*	10
Young, M. L.,	*North Hollywood*	10
Young, N. A.,	*Huntington Park*	10
Young, R. A.,	*Oakland*	1
Young, W. L.,	*Three Forks, Mont.*	29
Yuskis, A. S.,	*La Jolla*	22

— Z —

Zaiser, H. E.,	*Orange*	16
Zanger, H. G.,	*San Jose*	28
Zantiny, W. G.,	*Long Beach*	10
Zeff, M. G.,	*Berkeley*	1
Zeiler, A. H.,	*Los Angeles*	10
Zeiler, J.,	*Los Angeles*	10
Zeimer, I. S.,	*Stockton*	24
Zelinsky, F.,	*Los Angeles*	10
Zeller, W. C.,	*Visalia*	36
Zieber, R. L.,	*Santa Rosa*	33
Ziegler, E. E.,	*Chevy Chase, Md.*	23
Zimmerer, S. R.,	*Mecca*	18
Zimmerman, H.,	*Sacramento*	19
Zimmermann, W. T.,	*Los Angeles*	10
*Zirker, D. W.,	*Merced*	13
Zirkle, T. I.,	*Loma Linda*	21
Ziskind, E.,	*Los Angeles*	10
Zobel, A. J.,	*San Francisco*	23
Zobel, J. F.,	*San Francisco*	23
Zochert, L. W.,	*La Mesa*	22
Zombro, F. B.,	*Los Angeles*	10
Zook, A. J.,	*Burbank*	10
Zorb, G. A.,	*Los Angeles*	10
Zumwalt, E. R.,	*Tulare*	36
Zumwalt, F. H.,	*San Francisco*	23
Zumwalt, R. H.,	*San Francisco*	23

* * *

II. ASSOCIATE MEMBERS

Cummins, W. T.,	*San Francisco*	23
Godfrey, E. B.,	*Santa Fe, N. M.*	21
Leake, C. D.,	*San Francisco*	23
Rusk, G. Y.,	*San Francisco*	23
Weiss, C.,	*San Francisco*	23

* * *

III. HONORARY MEMBERS

Harris, H.,	*San Francisco*	23
King, J. C.,	*Riverside*	18

* * *

IV. RETIRED MEMBERS

Allen, F. M.,	*San Diego*	22
*Baker, C. Le B. J.,	*Point Loma*	22
Baker, F.,	*Point Loma*	22
*Ball, C. D.,	*Santa Ana*	16
Bertola, M.,	*San Francisco*	23
Bogue, H. A.,	*Ontario*	21
Brown, A.,	*San Francisco*	23
Browning, C. C.,	*Los Angeles*	10
*Clark, J. J.,	*Santa Ana*	16
Clark, J.,	*Gilroy*	28
Collins, A. W.,	*San Francisco*	23
Davis, B.,	*Los Gatos*	13
DePuy, E. S.,	*Oakland*	1
Dunsmoor, N. C.,	*Los Angeles*	10
Ely, L. W.,	*San Francisco*	28
Evans, G. H.,	*Berkeley*	23
Frederick, M. W.,	*Brentwood*	23
Fuller, R. N.,	*Tulare*	36
*Gatchell, W. LeF.,	*Chico*	2
Goodman, E.,	*San Francisco*	23
*Goodridge, H. A.,	*San Jose*	28
*Gray, F. P.,	*San Francisco*	23
*Grissim, J. D.,	*Oakland*	1
Gunn, Herbert,	*Monticello*	10
Hablutzel, C. E.,	*San Jose*	28
Harbert, E.,	*Stockton*	24
Henderson, J. J.,	*San Francisco*	23
Hogan, J. J.,	*Vallejo*	23
Houston, A. J.,	*San Francisco*	23
Hyman, S.,	*Los Altos*	23
Jean, G. W.,	*St. Petersburg, Florida*	27
Kahn, A. J.,	*Los Angeles*	23
King, H. R.,	*Winters*	38
Levison, C. C.,	*Sausalito*	23
Lindsay, W. K.,	*Sacramento*	19
Livingston, W. R.,	*Oxnard*	37
Lorini, R.,	*Paris, France*	22
MacDonald, E. A.,	*Beverly Hills*	21
MacLaughlin, W. E.,	*Los Angeles*	10
McClenahan, H. C.,	*San Francisco*	23
McDaniel, J. L.,	*San Fernando*	10
McKee, A. B.,	*Redwood City*	23
McVey, C. L.,	*Oakland*	1
Melvin, J. T.,	*Porterville*	36
Pope, E. W.,	*Carmel*	23
Power, H.,	*Palo Alto*	28
Quinn, W.,	*San Francisco*	23
*Renz, C.,	*Mill Valley*	23
Rogers, F. L.,	*Long Beach*	10
Rothganger, G.,	*Oakland*	1
Shattinger, C.,	*Los Altos*	28
Siebe, E. B.,	*San Francisco*	23
Simmons, G. C.,	*Inverness*	19
Smith, J. F.,	*San Francisco*	23
Somers, H.,	*Morgan Hill*	23
*Spencer, J. C.,	*Palo Alto*	23
Spiro, H.,	*San Francisco*	23
Spriggs, G. A.,	*Lomita*	23
Taylor, M. C.,	*San Francisco*	24
Vecki, V. G.,	*San Francisco*	23
Wall, A. S.,	*Los Angeles*	10
Waller, J. L.,	*San Francisco*	23
Ward, M. W.,	*San Francisco*	38
Waterman, H. J.,	*Berkeley*	23
Weirich, E. W.,	*Angels Camp*	24
Welty, C. F.,	*San Francisco*	23
*Wheeler, J. S.,	*Santa Cruz*	17
Whiffen, R. A.,	*San Jose*	28
Williams, E. H.,	*Palo Alto*	23
Winslow, T. H.,	*Oakland*	1
Worthington, G. B.,	*San Diego*	22
Yager, W. L.,	*Los Angeles*	10
Yates, E. M.,	*Santa Rosa*	33

In Memoriam

Deceased Members—Year 1937

NAME	CITY	COUNTY SOCIETY NO.
Alexander, Edgar William, July 21,	*San Francisco*	23
Alvarez, Luis Fernandez, May 24,	*Los Angeles*	10
Attwood, William Gillispie, July 14,	*Los Angeles*	10
Baker, Charlotte LeB. Johnson, October 31,	*Point Loma*	22
Ball, Charles Dexter, June 16,	*Santa Ana*	16
Barlow, W. Jarvis, September 4,	*Los Angeles*	10
Beck, John Edwin, April 8,	*Tulare*	36
Bell, Mabel T., September 27,	*Ventura*	37
Bennett, Laura B., November 7,	*San Pedro*	10
Bennette, Marie Antoinette, July 27,	*San Bernardino*	21
Bowen, Fred Phelps, October 9,	*Los Angeles*	10
Brem, Walter Vernon, November 19,	*Los Angeles*	10
Brown, Harry V., June 26,	*Glendale*	10
Brown, Newbern N., May 30,	*Bakersfield*	7
Busby, James L., February 23,	*Pasadena*	10
Carey, Henry Benjamin, February 4,	*San Francisco*	23
Clark, John I., November 3,	*Santa Ana*	16
Coe, Harry Carson, June 11,	*Oakland*	1
Denman, Claire H., January 12,	*Berkeley*	1
Downs, Alfred J., March 12,	*Los Angeles*	10
Dunlap, Albert Knight, January 19,	*Sacramento*	19
Eddy, Irving Herbert, March 8,	*Glendale*	10
Ellis, James A., May 1,	*Alameda*	1
Farmer, Lydia Etta, July 1,	*Folsom City*	10
Fehliman, William Edward, November 24,	*Santa Cruz*	29
Friedman, Joseph C., October 20,	*Banning*	18
Gatchell, Willis LeForrest, December 31,	*Stockton*	2
Ghrist, David Garrison, February 3,	*Los Angeles*	10
Goodridge, Hannah A., October 26,	*San Jose*	28
Gray, Frank Pierce, June 28,	*San Francisco*	23
Green, Louis David, January 14,	*San Francisco*	23
Grissim, John D., July 22,	*Oakland*	1
Gross, Harold G., October 28,	*Eureka*	5
Hay, Emil O., October 15,	*Los Angeles*	10
Haynes, John Randolph, October 30	*Los Angeles*	10
Heffernan, William T., December 30,	*San Diego*	6
Howell, Edgar Henry, December 30,	*San Francisco*	23
Hull, Leonard Charles, November 23,	*Hollister*	20
Jones, Charles Breckenfeld, March 14,	*Sacramento*	19
Kehr, Edwin Frank, October 31,	*Pasadena*	10
Kern, Bert C., September 5,	*Jackson*	19
Lenker, Walter Dora, January 30,	*San Bernardino*	21
Mabee, Melbourne, March 23,	*Santa Ana*	16
Martin, James J., March 23,	*Long Beach*	10
Miller, Frank W., November 1,	*Los Angeles*	10
Miller, Harold A., August 13,	*Alameda*	1
Minaker, Andrew J., January 16,	*San Francisco*	23
Millspaugh, Willard P., October 29,	*Los Angeles*	10
Moffitt, Thomas William, January 4,	*Hollywood*	10
Mountford, George Thomas, May 2,	*Coalinga*	4
Newmark, Philip, August 20,	*Los Angeles*	10
O'Connor, Thomas C., Jr., January 13,	*Lodi*	24
Otis, Margaret R., September 21,	*Los Angeles*	10
Peery, John Thomas, September 27,	*Corcoran*	8
Pruett, John F., March 17,	*San Francisco*	23
Rea, Thomas, December 1,	*Yreka*	5
Renz, Carl, January 22,	*Mill Valley*	23
Rook, Charles Wesley, April 15,	*Montrose*	10
Roth, George Henry, August 22,	*Los Angeles*	10
Schiller, Marie Margaret, September 12,	*Los Angeles*	10
Seawell, J. Walter, December 26,	*Healdsburg*	33
Shidler, George P., September 12,	*Torrance*	10
Smith, Albert Sidney J., November 13,	*San Jose*	28
Smith, Harlan Lewis, March 12,	*Fair Oaks*	19
Smith, Munford, June 28,	*Los Angeles*	10
Smith, R. Knight, April 18,	*San Francisco*	23
Solomon, Jacobus C., March 15,	*Los Angeles*	10
Spencer, John Campbell, July 4,	*Palo Alto*	28
Styan, William Earnshaw, November 24,	*San Francisco*	23
Sweet, Earl Bertrand, May 22,	*Los Angeles*	10
Sweet, Frank D., January 24,	*Long Beach*	10
Tomlinson, Richard Frank, March 13,	*San Francisco*	23
Trowbridge, Dwight Howe, May 4,	*Fresno*	4
Van Sickle, J. Russell, January 16,	*Santa Monica*	10
Wade, Lyman Trevitt, April 11,	*San Luis Obispo*	25
Wall, Albert Samuel, September 9,	*Los Angeles*	10
Webster, Oran Lamar, July 31,	*Holtville*	6
Wheeler, Joseph Suly, July 23,	*Santa Cruz*	29
Zirker, Daniel Webster, October 25,	*Merced*	13

SUPPLEMENT TO

CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association

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50 CENTS A YEAR

THE N. Y. ACADEMY OF MEDICINE
APR 20 1938
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I

Annual Session Program

Pasadena, California, May 9–12, 1938

Sixty-Seventh Annual Meeting

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II

Pre-Convention Bulletin

Reports of Officers and Committees

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SALUTATION FROM PRESIDENT MORROW

To Members of the California Medical Association—

Greetings:

I salute you in the name of our profession and extend to you a very cordial invitation to attend the sixty-seventh annual session of your Association in Pasadena, May 9 to 12.



HOWARD MORROW, M.D.
President, California Medical Association
1938

Our annual session affords the opportunity for every member to acquire information upon medical progress by hearing the presentations and discussions of competent clinicians and teachers. In addition, there are the inspiration and pleasure of meeting one's friends, forming new acquaintances, and engaging in the scheduled social functions. The personal benefits received more than compensate for the time spent in attending. A careful reading of the announcements, therefore, should induce you to plan to be present, and I sincerely trust that you will come.

At this time, I desire to officially extend expressions of appreciation to the section officers and speakers for their labor and contribution of time in preparing and taking part in the scheduled program. The success, the benefits, and the good that attends this session will be largely due to your efforts. We are grateful for your services and coöperation.

Lastly, may I emphasize anew that your membership affiliation is one of your most valuable possessions. Your loyalty to your county and state medical organizations will materially enhance the results accruing to you as a member. I bespeak your continued interest and sustained support, to the end that our Association and its constituent units may meet the problems of the times, and formulate well considered and directed solutions that will greatly help to secure public confidence and good will. We can lead, instead of being led.

Cordially,

HOWARD MORROW, *President.*

GUEST SPEAKERS AT THE SIXTY-SEVENTH ANNUAL SESSION CALIFORNIA MEDICAL ASSOCIATION

Speakers at General Meetings



UDO J. WILE, M.D.
Professor of Dermatology and Syphilology, University of Michigan Medical School, Ann Arbor, Michigan



ALFRED BLALOCK, M.D.
Professor of Surgery, Vanderbilt University, Nashville, Tennessee



TINSLEY R. HARRISON, M.D.
Associate Professor of Medicine, Vanderbilt University, Nashville, Tennessee



ALEXIS FRANK HARTMANN, M.D.
Associate Professor of Pediatrics, Washington University, School of Medicine, St. Louis, Missouri



WILLIAM W. ROBLEE
President-Elect

SECTION OFFICERS



EDWIN L. BRUCK
Chairman, General Medicine



HARLAN SHOEMAKER
Chairman, General Surgery



R. GLENN CRAIG
Chairman, Obstetrics and Gynecology



HOWARD F. WEST
Secretary, General Medicine



NELSON J. HOWARD
Secretary, General Surgery



JOHN N. EWER
Secretary, Obstetrics and Gynecology

SECTION OFFICERS



FRANK BAXTER
Chairman, Eye, Ear, Nose and Throat



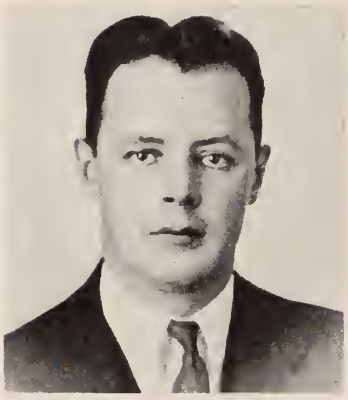
WILLIAM LEROY GARTH
Chairman, Anesthesiology



STANLEY O. CHAMBERS
Chairman, Dermatology and Syphilology



CLIFFORD B. WALKER
Secretary, Eye, Ear, Nose and Throat



JOHN G. DUNLOP
Secretary, Anesthesiology



NELSON PAUL ANDERSON
Secretary, Dermatology and Syphilology



FREDERIC C. BOST
Chairman, Industrial Medicine and Surgery



GEORGE H. SANDERSON
Secretary, Industrial Medicine and Surgery



FRED O. BUTLER
Chairman, Neuropsychiatry

SECTION OFFICERS



JOHN B. DOYLE
Secretary, Neuropsychiatry



GERTRUDE MOORE
Chairman, Pathology and Bacteriology



GEORGE D. MANER
Secretary, Pathology and Bacteriology



E. E. MOODY
Chairman, Pediatrics



HARTZELL H. RAY
Secretary, Pediatrics



JOHN D. LAWSON
Chairman, Radiology



KARL M. BONOFF
Secretary, Radiology



LLOYD E. KINDALL
Chairman, Urology



CARL F. RUSCHE
Secretary, Urology

Part I

PROGRAM

THE SIXTY-SEVENTH ANNUAL SESSION *of the* CALIFORNIA MEDICAL ASSOCIATION

TO BE HELD AT

HOTEL HUNTINGTON, PASADENA

MAY 9–12, 1938

OFFICERS AND COMMITTEES, 1938

GENERAL OFFICERS

HOWARD MORROW, San Francisco, President
WILLIAM W. ROBLEE, Riverside, President-Elect
EDWARD M. PALLETTE, Los Angeles, Past President
LOWELL S. GOIN, Los Angeles, Speaker of House of Delegates
JOHN H. GRAVES, San Francisco, Vice-Speaker of House of Delegates
MORTON R. GIBBONS, San Francisco, Chairman of Council
KARL L. SCHAUPP, San Francisco, Chairman, Executive Committee
FREDERICK C. WARNSHUIS, San Francisco, Secretary-Treasurer
GEORGE H. KRESS, Los Angeles, Editor
C. A. DUKES, Oakland, Chairman, Committee on Public Relations
HARTLEY F. PEART, San Francisco, General Counsel
HUBERT T. MORROW, Los Angeles, Associate General Counsel

COUNCILORS

First District

Calvert L. Emmons, Ontario (1938)
Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

Second District

Carl R. Howson, Los Angeles (1939)
Los Angeles County

Third District

Louis A. Packard, Bakersfield (1940)
Kern, San Luis Obispo, Santa Barbara, and Ventura Counties

Fourth District

Axcel E. Anderson, Fresno (1938)
Calaveras, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tulare and Tuolumne Counties

Fifth District

Alfred L. Phillips, Santa Cruz (1939)
Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties

Sixth District

Karl L. Schaupp, San Francisco (1940)
San Francisco County

Seventh District

Oliver D. Hamlin, Oakland (1938)
Alameda and Contra Costa Counties

Eighth District

Frederick N. Scatena, Sacramento (1939)
Alpine, Amador, Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties

Ninth District

Henry S. Rogers, Petaluma (1940)
Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties

Councilors-at-Large

Junius B. Harris, Sacramento (1940)
Harry H. Wilson, Los Angeles (1938)
C. O. Tanner, San Diego (1939)
William H. Kiger, Los Angeles (1940)
Morton R. Gibbons, San Francisco (1938)
T. Henshaw Kelly, San Francisco (1939)

DELEGATES AND ALTERNATES TO A. M. A.

Delegates	*Sessions*	*Alternates*
C. A. Dukes Oakland	(1938)	Edward N. Ewer Oakland
Edward M. Pallette Los Angeles	(1938)	W. H. Kiger Los Angeles
Robert A. Peers Colfax	(1938)	F. F. Gundrum Sacramento
William R. Molony, Sr. Los Angeles	(1938)	John C. Ruddock Los Angeles
Elbridge Best San Francisco	(1938-1939)	Robert S. Stone San Francisco
Lyell C. Kinney San Diego	(1938-1939)	Bon O. Adams Riverside
J. P. Nuttall Los Angeles	(1938-1939)	F. M. Pottenger Los Angeles

STANDING COMMITTEES

Executive Committee

The President, the President-elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Chairman of the Committee on Public Relations, the Past President, the Secretary-Treasurer and the Editor. (Karl L. Schaupp, chairman; Frederick C. Warnshuis, secretary.)

Auditing Committee

O. D. Hamlin, Oakland....1938
T. Henshaw Kelly, San Francisco....1938
Karl L. Schaupp (Chairman), San Francisco....1938
Members of the Auditing Committee are appointed each year by the Chairman of the Council.

Committee on Associated Societies and Technical Groups

Edwin L. Bruck, San Francisco....1938
William H. Geistweit, San Diego....1939
John V. Barrow (Chairman), Los Angeles....1940

Committee on Health and Public Instruction

Fred B. Clarke (Chairman), Long Beach....1938
W. R. P. Clark, San Francisco....1939
Benjamin W. Black, Oakland....1940

Committee on History and Obituaries

Frank R. Makinson (Chairman), Oakland....1938
J. Marion Read, San Francisco....1939
A. Elmer Belt, Los Angeles....1940
Secretary....Ex officio
Editor....Ex officio

Committee on Hospitals, Dispensaries and Clinics

George Dawson, Napa....1938
Daniel Crosby (Chairman), Oakland....1939
Karl L. Schaupp, San Francisco....1940

Committee on Industrial Practice

Morton R. Gibbons (Chairman), San Francisco....1938
Philip Stephens, Los Angeles....1939
Harry E. Zaiser, Orange....1940

Committee on Medical Defense

George G. Reinle (Chairman), Oakland....1938
Fred R. De Lappe, Modesto....1939
John P. Nuttall, Santa Monica....1940

Committee on Medical Economics

John H. Graves (Chairman), San Francisco....1938
William R. Molony, Sr., Los Angeles....1939
Edward M. Pallette, Los Angeles....1940

Committee on Medical Education and Medical Institutions

B. O. Raulston, Los Angeles....1938
Loren R. Chandler (Chairman), San Francisco....1939
John B. Doyle, Los Angeles....1940

Committee on Membership and Organization

E. Vincent Askey (Chairman), Los Angeles....1938
Dewey R. Powell, Stockton....1939
G. Dan Delprat, San Francisco....1940
Secretary....Ex officio

Committee on Postgraduate Activities

F. E. Clough, San Bernardino....1938
F. F. Gundrum, Sacramento....1939
John C. Ruddock (Chairman), Los Angeles....1940
Secretary....Ex officio

Committee on Publications

Ruggles A. Cushman, Talmage....1938
Oscar Reiss, Los Angeles....1939
Ralph Eusden (Chairman), Los Angeles....1940
Secretary....Ex officio
Editor....Ex officio

Committee on Public Policy and Legislation

Junius B. Harris (Chairman), Sacramento....1938
T. Henshaw Kelly, San Francisco....1939
E. T. Remmen, Glendale....1940
President....Ex officio
President-elect....Ex officio

Committee on Scientific Work

J. Homer Woolsey, Woodland....1938
F. M. Pottenger, Monrovia....1939
Lemuel P. Adams, Oakland....1940
Howard F. West, Secretary of Section on General Medicine....Ex officio
Nelson J. Howard, Secretary of Section on General Surgery....Ex officio
Frederick C. Warnshuis (Chairman)....Ex officio

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Charles A. Dukes. The Secretary is Frederick C. Warnshuis. The director of the Department of Public Relations is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is, ex officio, a member of the Council.

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.
Daniel Crosby, Chairman, Committee on Hospitals, Dispensaries, Clinics.
Morton R. Gibbons, Chairman, Committee on Industrial Practice.
E. Vincent Askey, Chairman, Committee on Membership and Organization.
John H. Graves, Chairman, Committee on Medical Economics.
Junius B. Harris, Chairman, Committee on Public Policy and Legislation.
Charles A. Dukes, Chairman, Cancer Commission.
John C. Ruddock, Chairman, Committee on Postgraduate Activities.
Howard Morrow, President of California Medical Association.
William W. Roblee, President-elect.
Frederick C. Warnshuis, Secretary-Treasurer.

Communications for the Public Relations Department should be addressed to the Director, Frederick C. Warnshuis, M.D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Orville Meland (Secretary for Southern Section), Los Angeles....1938
A. Herman Zeiler, Los Angeles....1938
Gertrude Moore, Oakland....1938
Harold Brunn, San Francisco....1939
Henry J. Ullmann, Santa Barbara....1939
Clarence G. Toland, Los Angeles....1939
Charles A. Dukes (Chairman), Oakland....1940
Lyell C. Kinney (Vice-Chairman), San Diego....1940
Otto H. Pflueger (Secretary), San Francisco....1940

Communications for the Cancer Commission should be addressed to the secretary, Otto H. Pfleuger, M.D., Room 2004, 450 Sutter Street, San Francisco.

SPECIAL COMMITTEES

Committee on a Qualifying Certificate (Basic Science) Law

George H. Kress (General Chairman)....Los Angeles
Morton R. Gibbons (Chairman for Bay Region)....San Francisco
Edward M. Pallette (Chairman for Southern California)....Los Angeles
Junius B. Harris (Chairman for Remainder of State)....Sacramento

Committee on Animal Experimentation

Philip K. Gilman (Chairman)....San Francisco
Charles A. Dukes....Oakland
Loren R. Chandler....San Francisco

Committee on Maternal Welfare

Lyle G. McNeile (Chairman)....Los Angeles
T. Henshaw Kelly....San Francisco
Ralph J. Thompson....Los Angeles
T. Floyd Bell....Oakland
Hans F. Schluter....Sacramento

Committee on Golden Gate International Exposition

T. Henshaw Kelly (Chairman)....San Francisco
Edward M. Pallette....Los Angeles
Frederick C. Warnshuis....San Francisco
Charles A. Dukes....Oakland
Karl Meyer....San Francisco
Hartley F. Peart....San Francisco

Committee on Syphilis

Howard Morrow (Chairman)....San Francisco
Charles W. Barnett....San Francisco
William H. Goeckerman....Los Angeles

Committee on California Medical Economic Survey

Edward M. Pallette (Chairman)....Los Angeles
Howard Morrow....San Francisco
George H. Kress....Los Angeles

Local Convention Committees

Local Committee on Arrangements—Pasadena Session

Paul C. Blaisdell (Chairman)....Pasadena
L. Grant Baldwin....Pasadena
Edward Jones....Pasadena
W. J. Woolston....Pasadena

Committee in Charge of Public Meeting

R. C. Olmstead....Pasadena
Lyle G. Craig....Pasadena
E. D. Kremers....Pasadena
Fred B. Clarke....Long Beach
George H. Kress....Los Angeles
George D. Maner....Los Angeles

Committee on Transportation

Harry F. Markolf (Chairman)....Pasadena
Russell M. Decker....Pasadena
Leland M. Evans....Pasadena
W. G. Scanlon....Pasadena
C. H. Briggs....Pasadena

Committees on Golf

Edward B. Dewey (Chairman)....Pasadena
Robert K. Gustafson....Pasadena
Harvey J. Forbes....Pasadena
Alvin Foord....Pasadena

REGISTRATION INFORMATION

Registration and Information. The registration and information desk is located in the patio, Hotel Huntington. All persons attending the convention, whether members or not, are requested to register immediately on arrival. Beginning Monday, May 9, registration secretaries will be on duty daily from 9 a. m. until 7 p. m.

Programs and "Pre-Convention Bulletin." The registration clerks will give to every member a copy of the program. The "Pre-Convention Bulletin" will be printed in the April issue of CALIFORNIA AND WESTERN MEDICINE. Delegates and alternates are especially requested to read the reports of officers and committees.

Guests and Visitors. All guests and visitors are requested to register. All general meetings and scientific meetings are open to visitors and guests.

Badges. Four kinds of badges will be issued by the registration bureau:

1. *Members.* Only active, associate, retired or honorary members of the California Medical Association will be given the usual membership badge.
2. *Guests.* A guest badge will be issued to all fraternal delegates and visiting physicians who are attending this year's session.
3. *Delegates and Alternates.* The usual official badge for each delegate and alternate is provided for this purpose, and will be issued only to one authorized to wear it.
4. *Officers.* An official badge is provided for all officers and members of the Council.

Suggestions and Constructive Criticism. The officers and committees have tried to do everything possible to make the session a success. Suggestions and constructive criticism calculated to make future sessions more useful will be welcomed by any of the officers. Complaints of whatever character should be promptly made at the registration desk, where they will receive attention.

General Announcements

1. Members are requested to register and obtain their copy of official program and special announcements.
2. Delegates will please file their credentials with the Credentials Committee between 7:00 and 8:00 p. m., Monday, May 9.
3. *Special Announcements:* For these, consult bulletin board.
4. *Visit the Exhibits:* Located in the Patio.
5. *President's Dinner:* Guests of the Hotel Huntington will obtain special tickets from room clerk. Others will obtain banquet tickets at the registration desk. Price $2.50 per plate.
6. Section meeting places are posted on the lobby directory.
7. For general or special information, consult the clerks at the registration desk.

MEMBERS OF HOUSE OF DELEGATES—35th ANNUAL SESSION

TOTAL DELEGATES (154)

DELEGATES EX OFFICIO (23)

Howard Morrow, San Francisco.....President
William W. Roblee, Riverside.....President-elect
Edward M. Pallette, Los Angeles.....Past President
Lowell S. Goin, Los Angeles..Speaker of House of Delegates
John H. Graves, San Francisco.....
.....Vice-Speaker of House of Delegates
Frederick C. Warnshuis, San Francisco.....
.....Secretary-Treasurer
George H. Kress, Los Angeles.....Editor
C. L. Emmons, Riverside (1938).....Councilor 1st District
Carl R. Howson, Los Angeles (1939)..Councilor 2nd District
Louis A. Packard, Bakersfield (1940).....
.....Councilor 3rd District
Axcel E. Anderson, Fresno (1938).....Councilor 4th District
Alfred L. Phillips, Santa Cruz (1939)..Councilor 5th District
Karl L Schaupp, San Francisco (1940).....
.....Councilor 6th District
Oliver D. Hamlin, Oakland (1938).....Councilor 7th District
Frederick N. Scatena, Sacramento (1939).....
.....Councilor 8th District
Henry S. Rogers, Petaluma (1940).....Councilor 9th District
Harry H. Wilson, Los Angeles (1938).....Councilor-at-Large
C. O. Tanner, San Diego (1939).....Councilor-at-Large
William H. Kiger, Los Angeles (1940)....Councilor-at-Large
Morton R. Gibbons, San Francisco (1938).....
.....Councilor-at-Large
T. Henshaw Kelly, San Francisco (1939).....
.....Councilor-at-Large
Junius B. Harris, Sacramento (1940).....Councilor-at-Large
C. A. Dukes, Oakland.....
.....Chairman, Committee on Public Relations

ELECTED DELEGATES

Delegates	*Alternates*
Alameda County (11)	
A. A. Alexander	T. F. Bell
Dorothy Allen	W. G. Donald
Leonard Barnard	Fred Ewing
Clarence A. DePuy	Lloyd Kindall
John Dougherty	George Nesche
Edward N. Ewer	Robert S. Peers
Sumner Everingham	T. Eric Reynolds
H. Gordon MacLean	A. C. Seifert
Frank R. Makinson	D. D. Toffelmier
George G. Reinle	H. G. Trimble
H. J. Templeton	H. H. Appeldorn
Butte County (1)	
Joseph O. Chiapella	N. T. Enloe
Contra Costa County (1)	
Sol N. Weil	L. H. Fraser
Fresno County (3)	
G. W. Walker	C. I. Pendergrass
E. J. Schmidt	S. A. Quimby
R. S. Scott	B. Sorauf
Humboldt County (1)	
Allan Watson	Curtis Lane Falk
Imperial County (1)	
L. C. House	Phillip Hodgkin
Kern County (1)	
C. S. Compton	F. J. Gundry
Kings County (1)	
Name not received	Name not received
Lassen-Plumas-Modoc Counties (1)	
Name not received	Name not received
Los Angeles County (45)	
L. A. Alesen	F. X. Ammann
E. Vincent Askey	C. Max Anderson
Samuel Ayres, Jr.	V. L. Andrews
Wilbur Bailey	A. A. Blatherwick
Harold Dewey Barnard	Lewis P. Bolander
Karl M. Bonoff	Henry T. S. Bonesteel
T. D. Caruso	H. B. Breitman
H. L. Charles	E. M. Burns
Fred B. Clarke	O. W. Butler
Walter R. Crane	Donald Cass
John W. Crossan	R. Manning Clarke
William H. Daniel	A. B. Cooke
Edward B. Dewey	Cyril B. Courville
George Dock	Charles H. Cowgill
Wallace Dodge	Egerton Crispin
Ralph B. Eusden	R. L. Cunningham
Alvin G. Foord	Wirt B. Dakin
Henry C. Gernand	Kenneth S. Davis
Orrie Ghrist	John B. Doyle
V. J. Keating	Roy E. Fallas
E. Eric Larson	William V. C. Francis
William H. Leake	John D. Gillis
George D. Maner	Leland Hawkins
William R. Molony, Sr.	Charles M. Hayes
E. Earl Moody	Malcolm R. Hill
Thomas Chalmers Myers	A. B. Hromadka
John W. Nevius	Morrill L. Ilsley
John P. Nuttall	Isaac H. Jones
Frank W. Otto	W. E. Macpherson
Charles E. Phillips	Orville Meland
Sterling N. Pierce	Robert J. Moes
F. M. Pottenger, Jr.	George H. Patterson
H. A. Putnam	Paul A. Quaintance
Robert E. Ramsay	Marcus Rabwin
E. T. Remmen	Oscar Reiss
John C. Ruddock	Paul B. Roen
Philip Stephens	H. E. Schiffbauer
F. C. Swearingen	V. DeMott Sedgwick
R. G. Taylor	Kenneth E. Smiley
Roy E. Thomas	Willard Stone
Donald G. Tollefson	Roy A. Terry
George D. Wells	H. V. Van Fleet
Walter Wessels	Harry J. Wiley
Howard F. West	Burnett W. Wright
A. Herman Zeiler	Charles S. Young
Marin County (1)	
Anne H. Brady	Carl W. Clark
Mendocino-Lake Counties (1)	
R. A. Cushman	Thomas P. Hill
Merced County (1)	
E. A. Jackson	A. C. Atwood
Monterey County (2)	
James H. McPharlis	W. H. Farr
Mast Wolfson	J. A. Merrill
Napa County (1)	
George I. Dawson	Dwight H. Murray
Orange County (3)	
G. Wendell Olson	Milo K. Tedstrom
Dexter Ball	Harold F. Gobar
Harry Huffman	Merrill Hollingsworth
Placer County (1)	
Lucas W. Empey	Mildred E. Thoren
Riverside County (2)	
A. L. Bramkamp	H. L. Ratliff
Bon O. Adams	R. B. McCarty
Sacramento County (3)	
Frank MacDonald	Wayne Pollock
Raymond Wallerius	Paul Guttman
Harry Kanner	Ralph Teall
San Benito County (1)	
R. L. Hull	R. S. Geen
San Bernardino County (3)	
A. D. Neubert	T. I. Zirkle
Walter Cherry	R. C. Nichols
X. Olsen	A. L. Weber
San Diego County (6)	
Winston C. Crabtree	B. F. Eager
James F. Churchill	Ralph Kaysen
S. J. McClendon	W. L. Garth
F. E. Toomey	J. G. Omelvena
A. J. Cooper	W. W. Belford
Willard H. Newman	C. W. Lane
San Francisco County (17)	
H. Glenn Bell	Zera E. Bolin
Elbridge J. Best	Leroy Brooks
Frederic C. Bost	Howard A. Brown
Edwin L. Bruck	John W. Cline
G. Dan Delprat	Leo Henry Garland
J. C. Geiger	Ernst Gehrels
Thomas E. Gibson	Frank Hand
Philip K. Gilman	Nelson J. Howard
Harold A. Hill	Thomas J. Lennon
Irving S. Ingber	Mary Jones Mentzer
Alson R. Kilgore	James W. Morgan
Stanley H. Mentzer	Gunther W. Nagel
Robert R. Newell	Gerald B. O'Connor
George Warren Pierce	Leon O. Parker
Dohrmann K. Pischel	Robert S. Stone
John J. Sampson	David A. Wood
Roland P. Seitz	Rodney A. Yoell
San Joaquin County (3)	
D. R. Powell	C. A. Broaddus
G. H. Sanderson	G. H. Rohrbacher
J. F. Doughty	C. V. Thompson
San Luis Obispo County (1)	
Charles R. Kennedy	Earl B. King
San Mateo County (2)	
Hartzell H. Ray	N. D. Morrison
J. Garwood Bridgman	H. Wade Macomber

Delegates	*Alternates*
Santa Barbara County (3)	
H. E. Henderson	Hugh Freidell
Caleb Stone	Dan M. Clark
E. L. Markthaler	P. A. Gray
Santa Clara County (4)	
Stanley R. Kneeshaw	Merlin T.-R. Maynard
Cecil M. Burchfiel	George L. Barry
Russel V. Lee	John H. Shephard
C. Kelly Canelo	Earl O. G. Schmitt
Santa Cruz County (1)	
M. D. McPherson	R. Rood
Shasta County (1)	
Name not received	Name not received
Siskiyou County (1)	
James B. McQuire	Edward F. Carlson
Solano County (1)	
John W. Green	Durward B. Park

Alternates	*Delegates*
Sonoma County (1)	
A. A. Thurlow	L. W. Hines
Stanislaus County (1)	
R. S. Hiatt	Hans Hartman
Tehama County (1)	
O. T. Wood	R. G. Frey
Tulare County (1)	
R. C. Hill	Austin V. Miller
Ventura County (1)	
G. C. Coffey	A. A. Morrison
Yolo-Colusa-Glenn Counties (1)	
John H. Woolsey	Joseph E. Tillotson
Yuba-Sutter Counties (1)	
Stanley Parkinson	E. E. Gray

Schedule of Daily Meetings

Place	Monday		Tuesday		Wednesday		Thursday
	10:00 A. M.	1:30-4:00 P. M.	8:30-11:00 A. M.	1:00 P. M.	8:30-11:00 A. M.	1:30-4:00 P. M.	9:00-12:00 A. M.
Ballroom	Opening General Meeting	Medicine	Medicine 11:15 Second General Meeting	AFTERNOON OPEN FOR ENTERTAINMENT	Medicine and Pediatrics 11:15 Third General Meeting	† Symposium on "Shock"	Medicine
Crystal Room		Surgery	Surgery		Surgery	Industrial Medicine and Surgery	Surgery
Tap Room		Obstetrics and Gynecology	Neuro-psychiatry		Obstetrics and Gynecology		
Cottage "A"		Eye, Ear, Nose and Throat	Eye, Ear, Nose and Throat		Urology	Urology	
Cottage "B"		Dermatology and Syphilology	Dermatology and Syphilology			Neuro-psychiatry	
Cottage "C"		Pediatrics	Radiology and Industrial Medicine				
Cottage "D"		Industrial Medicine	Pathology and Bacteriology		Radiology	Radiology	
Cottage "E"		Pathology and Bacteriology					
Cottage "F"		Anesthesiology					
Rooms 447-48	Council		Council		Council		
Ballroom		8:00 P.M. House of Delegates		7:30 P. M. President's Dinner		8:00 P. M. House of Delegates	
Dining Room		9:00 P. M. Musicale					
Private Dining Room	7:30 A. M. Past Presidents' Breakfast						
Crystal Room						4:15 P. M. Medical Society of the State of California	

† On Wednesday afternoon the following Sections will join in a Symposium on "Shock": Medicine, Surgery, Obstetrics and Gynecology, Eye, Ear, Nose and Throat, Pediatrics, Pathology and Anesthesiology.

PROGRAM: BY DAYS

Sunday, May 8

9:00 a. m. to 4:30 p. m.—Clinical Pathological Conference. (To be held in Room 359 Science Building, University of Southern California, Thirty-sixth Place and University Avenue, Los Angeles.)

10:00 a. m. to 4:00 p. m.—Radiological Conference. (To be held in Main Ballroom, Huntington Hotel.)

8:00 p. m.—Council Meeting.

Monday, May 9

10:00 a. m.—Opening General Meeting. (Main Ballroom, Huntington Hotel.)

1:30 p. m.—Scientific Section Meetings.

8:00 p. m.—House of Delegates: First Meeting.

Tuesday, May 10

7:30 a. m.—Past Presidents' Breakfast.

8:30 a. m.—Section Meetings.

11:15 a. m.—General Meeting—Clinical-Pathological Conference.

1:00-6:00 p. m.—Recreation. (No scientific meetings during this period.)

7:30 p. m.—President's Dinner; Reception and Dance.

Wednesday, May 11

8:30 a. m.—Section Meetings.

11:15 a. m.—General Meeting.

1:30 p. m.—Section Meetings.

4:15 p. m.—Medical Society of State of California.

8:15 p. m.—House of Delegates.

Thursday, May 12

8:30 a. m.—Section Meetings.

9:00 a. m.—Council Meeting.

* * *

Note.—Council meets daily.

Watch bulletin board for special announcements.

Visit Commercial Exhibits.

Secure tickets for President's dinner at registration desk *before* Tuesday noon.

I—GENERAL MEETINGS

All General Meetings will be held in the Main Ballroom, Hotel Huntington

First General Meeting

Monday, May 9, 10 a. m.

1. *Address of Welcome*—George H. Kress, M. D., President, Los Angeles County Medical Association.
2. *Announcements*—Secretary F. C. Warnshuis, M. D.
3. *President's Annual Address*—Howard Morrow, M. D., San Francisco.
4. *The Relation of Syphilis to Surgical Problems*—Udo J. Wile, M. D., Ann Arbor, Michigan, Professor of Dermatology and Syphilology, University of Michigan. (By invitation.)

Second General Meeting

Tuesday, May 10, 11:15 a. m.

President Howard Morrow, Presiding

1. *Clinical-Pathological Conference*—Conducted by Alfred Blalock, M. D., Professor of Surgery, Vanderbilt University, Nashville, Tennessee; and Tinsley R. Harrison, M. D., Associate Professor of Medicine, Vanderbilt University, Nashville, Tennessee.

 Note.—The clinical history and laboratory findings of three cases will be presented. These case reports will then be discussed and diagnoses suggested. Following this, Dr. A. G. Foord will present the protocols and final pathological diagnoses.

Third General Meeting

Wednesday, May 11, 11:15 a. m.

President Howard Morrow, Presiding

1. *The Clinicol Usage of Estrogenic Hormones*—C. Frederic Fluhmann, M.D., Associate Professor of Obstetrics and Gynecology, Stanford University, California. (By invitation.)

 Modern investigations have revealed a wide distribution of substances capable of stimulating the accessory genital organs. The "estrogenic hormones" are of clinical importance from two standpoints: (1) as diagnostic tests, (2) as therapeutic agents. The present paper is a discussion of the value of such tests and of the indications, preparations, and methods of administration of these substances.

2. *Sulfanilamid, with Particular Reference to Changes in the Acid-Base Bolance and to Methemoglobin Formation*—Alexis F. Hartmann, M. D., Professor of Pediatrics, Washington University, St. Louis, Missouri.

 Very promptly following the administration of sulfanilamid to normal human subjects, there occur hyperpnea and rise in plasma p^H, to be followed promptly by excretion of alkali into the urine and reduction of plasma bicarbonate. The early effect, then, is the production of a carbon dioxid deficit type of alkalosis, and not acidosis. Later, because of the apparently compensatory reduction of plasma bicarbonate, total fixed base deficiency may occur which may facilitate the development of acidosis by contributing factors.

 The development of methemoglobinemia may very effectively be prevented or relieved by methylene blue.

II—SECTION MEETINGS

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

I.—General Medicine (1-15) 11
II.—General Surgery (16-36) 13
III.—Obstetrics and Gynecology (37-46) 15
IV.—Eye, Ear, Nose and Throat (47-52a) 16
V.—Anesthesiology (53-57) 17
VI.—Dermatology and Syphilology (58-70) 17
VII.—Industrial Medicine and Surgery (71-79) 18
VIII.—Neuropsychiatry (80-89) 19
IX.—Pathology and Bacteriology (90-98) 20
X.—Pediatrics (99-107) 21
XI.—Radiology (108-121) 22
XII.—Urology (122-134) 23

Rules Regarding Papers and Discussions at the State Meetings

Upon the recommendation of the Executive Committee the following rules regarding papers have been adopted by the Council:

1. The maximum time that may be consumed by any paper is fifteen minutes, provided that not to exceed ten minutes' latitude may be allowed invited guests at the discretion of the presiding chairman.

2. Motions from the floor to extend the time of an author may be entertained by the presiding officer.

3. The maximum time permitted any individual to discuss a paper is four minutes. This also applies to the author in closing his discussion. No speaker may discuss more than once any one subject.

4. A copy of each and every paper presented at the state meeting must be in the hands of the chairman or secretary of the section or in the hands of the general secretary before the paper is presented.

5. All papers read at the annual meeting shall be published in full in California and Western Medicine as soon after the meeting as space will permit, or at the option of the author, an abstract of the paper of about one column in length shall be published as soon as possible after the meeting, with reprints in full of the entire paper (the cost of setting up type for the reprint to be borne by the Association, and all other costs to be borne by the author).

6. Articles are accepted for publication on condition that they are contributed solely to California and Western Medicine. Authors desiring to publish their papers elsewhere than in the Journal may have their manuscripts returned to them upon written request to the editor.

7. No paper will be accepted by the General Program Committee nor by Section Program Committees unless accompanied by a synopsis of not to exceed fifty words.

8. Papers shall not be "read by title."

9. No member may present more than one paper at any one state meeting, provided that a member may be a collaborator on more than one paper, if these papers are presented by different authors.

10. Failure on the part of an author to present a paper precludes acceptance of future papers from such author for a period of two years, unless the author explains to the satisfaction of the Executive Committee his inability to fulfill his obligation.

Section Papers: How Numbered

For convenience in reference, papers are numbered in serial sequence for the entire session, instead of a separate sequence for each section.

Business Meetings of Sections

Time of business meetings and elections of officers of sections will be scheduled on section blackboards by section secretaries, and through preliminary announcements by section chairmen.

Unless otherwise announced, the business meetings of each section and the election of officers will be held immediately after the reading of the second paper on the second day's section program.

I

GENERAL MEDICINE SECTION

Edwin L. Bruck, M.D., *Chairman*
384 Post Street, San Francisco

Howard F. West, M.D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

First Meeting—Ballroom*

Monday, May 9, 1:30 p. m.

1. *Electrocardiographic Study of Coronary Thrombosis—The Value of the Chest Lead in Determining the Location of the Infarct*—William H. Leake, M.D., 1930 Wilshire Boulevard, Los Angeles; G. Creswell Burns, M.D., 1052 West Sixth Street, Los Angeles; Wilbur A. Beckett, M.D., 3875 Wilshire Boulevard, Los Angeles.

 The death charts of approximately one hundred and fifty patients dying as a result of coronary thrombosis have been reviewed. The electrocardiograms and autopsy findings were analyzed in each case in an attempt to determine the value of the chest lead in localizing the infarct.

 Discussion by John Kent Lewis, M.D., San Francisco; E. Richmond Ware, M.D., Los Angeles.

2. *A Concept of Angina Pectoris with Applications to Therapy*—M. H. Nathanson, M.D., 2007 Wilshire Boulevard, Los Angeles.

 The clinical syndrome, angina pectoris, cannot be adequately explained solely on the basis of occlusive coronary disease with myocardial ischemia. Evidence is presented implicating the cardiac sympathetic enervation and a concept suggested that angina pectoris results from the synergistic action of myocardial ischemia and sympathetic nervous activity. Experiments demonstrating methods to reduce cardiac sympathetic tonus are presented and the practical application to therapy is suggested.

 Discussion by John J. Sampson, M.D., San Francisco; James F. Churchill, M.D., San Diego.

3. *Cardiac Dyspnea*—Tinsley R. Harrison, M.D. (by invitation), Vanderbilt University, Nashville, Tennessee.

 The address will include a discussion of the types of dyspnea occurring in patients with heart disease, the underlying and precipitating causes of such dyspnea, the effects of dyspnea, and the treatment of this symptom.

4. *Heart Failure in Vitamin B_1 Deficiency*—Clifford B. Cherry, M.D., 1030 Kansas Street, San Francisco.

 Heart failure due to deficiency of vitamin B_1 is of not infrequent occurrence. Its early recognition is of especial importance because an adequate therapy is available. Diagnosis and treatment are discussed, and the return of the heart to normal size under treatment is illustrated by roentgenograms.

 Discussion by Jay Marion Read, M.D., San Francisco; Arthur A. Marlow, M.D., La Jolla.

5. *The Heart in Pneumoconiosis*—Charles B. Coggin, M.D., Donald E. Griggs, M.D., and Walter D. Stilson, M.D., 312 North Boyle Avenue, Los Angeles.

 This is a study of the effect of pneumoconiosis upon the heart as it can be elicited clinically, by routine x-ray films, and as it is found at autopsy. The clinical records, x-ray files, and protocols of one hundred autopsied cases at Los Angeles County Hospital are reviewed.

 Discussion by R. Manning Clarke, M. D., Los Angeles; Roy E. Thomas, M. D., Los Angeles.

*Following the adjournment of this program, the California Heart Association will hold its annual meeting in this room. All members of the Heart Association and others interested are urged to remain.

Second Meeting—Ballroom

Tuesday, May 10, 8:30 a. m.

6. *Trichiniasis: Report of an Outbreak of Twenty-Five Cases*—Hyman I. Vener, M.D., C.P.H.; George M. Stevens, M.D., Los Angeles City Health Department, 116 West Temple Street, Los Angeles.

 An epidemiological investigation conducted by the Department of Epidemiology, Los Angeles City Health Department, and confirmed by definite laboratory procedures. The mild clinical manifestations and the necessity for caution are stressed.

 Many instances of supposed influenza with prolonged convalescence could be due to trichiniasis. Laboratory assistance is of value, but does not indicate the clinical severity. Recommendations for control are given.

 Discussion by Edward M. Butt, M.D., Los Angeles; Karl F. Meyer, M.D., Hooper Foundation, University of California, San Francisco.

7. *Clinical Management of Goiter*—Mayo H. Soley, M.D., University of California Hospital, San Francisco.

 Colloid goiters can be largely eliminated by the use of iodin in endemic areas. Nontoxic nodular goiters, toxic nodular goiters, and the majority of toxic diffuse goiters should be subtotally removed. Mortality can be reduced by preoperative preparation of all patients with toxic goiters. From 30 to 40 per cent of patients with toxic diffuse goiters can be successfully treated with x-ray.

 Discussion by Leon Goldman, M.D., San Francisco; Evelyn Anderson, M.D., San Francisco.

8. *Chairman's Address*—Edwin L. Bruck, M.D., 384 Post Street, San Francisco.

9. *The Identification of Fungi Causing Disease in California*—Robert A. Stewart, M.D., University of California Hospital, San Francisco.

 Two general types of procedures are employed in the identification of fungi: descriptive morphology and physiological activity as seen in culture solutions. Difficulty arises when the attempt is made to correlate the results obtained by one method with that of the other. Resolution is possible by the use of chemically defined culture solutions.

 Discussion by H. E. Miller, M.D., San Francisco; N. N. Epstein, M.D., San Francisco.

10. *Dermatomyositis: Report of Case Associated with Rheumatic Heart Disease*—Frederick Kellogg, M.D., 211 Cherry Avenue, Long Beach; Felix Cunha, M.D., 450 Sutter Street, San Francisco.

 A case of dermatomyositis following smallpox vaccination and associated with rheumatic heart disease is presented. The clinical aspects and various forms of therapy are outlined. Particular emphasis is laid on the prevention of deformity during acute stages and on physiotherapy in rehabilitation.

 The paper is supplemented by slides of photographs, microphotographs, and roentgenograms.

 Discussion by William J. Kerr, M.D., San Francisco; Irwin C. Schumacher, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

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Third Meeting—Ballroom

Wednesday, May 11, 8:30 a. m.

SYMPOSIUM ON VITAMINS

This will be a joint meeting of the Sections on Pediatrics and General Medicine.

The program of this joint meeting is printed under the second meeting of the Pediatrics Section. (See page 21.)

Fourth Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK—ACUTE CIRCULATORY FAILURE

This symposium will be presented by Alfred Blalock, M.D., Professor of Surgery, and Tinsely R. Harrison, M.D., Professor of Medicine, Vanderbilt University School of Medicine, Nashville, Tennessee.

(a) *Peripheral Circulatory Failure*—Alfred Blalock, M.D.

Peripheral circulatory failure is divided into three types: (1) hematogenic, (2) neurogenic, and (3) vasogenic. The reasons for this division and the etiology of each type are considered. The treatment of the several types varies somewhat, according to the cause. Various forms of treatment will be discussed.

(b) *Acute Cardiac Failure Simulating Peripheral Circulatory Failure*—Tinsley R. Harrison, M.D.

Acute cardiac failure is of three types: (1) Sudden death due either to ventricular fibrillations, or cardiac standstill; (2) cardiac syncope, usually brought about by sudden slowing of the rate; and (3) acute cardiac collapse due either to acute myocardial injury, to severe tachycardia, or to sudden mechanical hindrance to the action of the heart. The treatment of these several conditions varies according to the cause. A brief discussion of each of the different causes and of the proper treatment will be given.

Discussion by William Dock, M.D., Professor of Pathology, Stanford Medical School, San Francisco.

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Fifth Meeting—Ballroom

Thursday, May 12, 9:00 a. m.

11. *Routine Pulmonary Radiography of Prison Entrants*—George C. Lowell, M.D., Medical Department, California State Prison, San Quentin.

 All prisoners, on entrance to San Quentin, have a radiograph of the chest taken. The series of two thousand entrants shows the radiological evidence of tuberculosis in some form in about ten per cent of all cases, active tuberculosis being found in about one per cent of all cases. Methods of treatment are outlined and unusual cases cited.

 Discussion by Howard Ruggles, M.D., San Francisco; Cabot Brown, M.D., San Francisco.

12. *Tuberculosis in San Quentin State Prison*—Leo L. Stanley, M.D., Medical Department, California State Prison, San Quentin.

 Here are presented excerpts from the biennial medical reports of San Quentin Prison since its establishment in 1851. Accompanying is a graph showing increase in prison population, peaks of incidence of tuberculosis, and death rate. Mortality decreased from seventeen per thousand in 1887 to two per thousand in 1937.

 Discussion by Howard Ruggles, M.D., San Francisco; Cabot Brown, M.D., San Francisco.

13. *Geriatrics*—Leonard J. Brunie, M.D., 60 South Grand, Pasadena.

 This paper introduces a study in longevity, and is a careful analysis of the heredity, habits, medical history, and clinical findings of those fortunate ones who are found active and in good health in the ninth decade of their lives. This is a preliminary study which it is hoped will stimulate interest in that rapidly developing new science, geriatrics.

 Discussion by Robert E. Ramsay, M.D., Pasadena; Franklyn R. Nuzum, M.D., Santa Barbara.

14. *Renal Function in the Aged*—L. Dale Huffman, M.D., 6305 Yucca Street, Hollywood.

 Modern methods of testing renal function should be applied in the examination of persons of advanced age. The reliability and prognostic significance of the findings resulting from such tests are analyzed. Needed caution in the interpretation of them is discussed.

 Discussion by Donald J. Frick, M.D., Los Angeles; Roland G. Cummings, M.D., Los Angeles.

15. *Clinical Evaluation of the Use of Adrenal Cortex in Treating Childhood Asthma*—F. M. Pottenger, Jr., M.D., 1930 Wilshire Boulevard, Los Angeles.

This paper deals with the continued use of the adrenal cortex, mineralized diet, and associated therapy, reported before this Association in 1935. The results discussed will deal with those patients who have been under observation for a period of one or more years. Certain findings in these cases will be discussed and particular reference will be laid on the regimen followed in their treatment.

Discussion by E. Kost Shelton, M.D., Los Angeles; Leland Hunnicutt, M.D., Pasadena.

II

GENERAL SURGERY SECTION*

HARLAN SHOEMAKER, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles
NELSON J. HOWARD, M.D., *Secretary*
2957 Divisadero Street, San Francisco
RAY B. MCCARTY, M.D., *Assistant Secretary*
3616 Main Street. Riverside

First Meeting—Crystal Room

Monday, May 9, 1:30 p. m.

16. *Torsion of the Omentum*—Phillip J. Lipsett, M.D., 400 Twenty-ninth Street, Oakland.

A review of the literature, particularly the series of cases by Corner and Pinches, and that of Morris. A detailed discussion of the etiology and diagnosis of the condition. The differential diagnosis from acute appendicitis, with which it is most frequently confused, is stressed. Two additional cases are reported in detail. An analysis of eighteen cases from the literature, not previously included in other studies, and a plea for more careful observation in this condition to help in the diagnosis and greater knowledge of etiological factors.

Discussion by Thomas F. Mullen, M. D., San Francisco; George Rhodes, M.D., San Francisco.

17. *Acute Pancreatitis*—Norman C. Paine, M. D., 118 West Wilson Avenue, Glendale.

Six cases of acute pancreatitis observed in one year led the author to study the sixty-four cases with this diagnosis in the files of the Los Angeles General Hospital. Half of these cases occurred in the last year. Recent literature and experimental work have been reviewed. Conclusions suggest standardization of preliminary laboratory procedure and indications for surgery.

Discussion by W. H. Olds, M.D., Los Angeles; Frank MacDonald, M.D., Sacramento.

18. *Auscultation of the Abdomen*—John Homer Woolsey, M.D., Woodland Clinic, Woodland.

Clinical application of auscultation of the abdomen will be discussed, with attention to the cause for the absence or increase of peristalsis; report of observation in various clinical conditions and in the postoperative course; and interpretation of the same.

Discussion by Charles Sturgeon, M.D., Los Angeles; Frank Wiebe, M.D., Salinas.

19. *Problems in Diagnosis of Acute Appendicitis*—Thomas O. Burger, M.D., and Harold C. Torbert, M.D., 2120 Fourth Avenue, San Diego.

Review of 449 cases of acute appendicitis, 26.9 per cent of which were ruptured at time cases were referred to us, with emphasis on diagnostic aspects. Fourteen atypical modes of onset noted, emphasis on which had led practitioner into error. Occurrence of symptoms and findings when appendix is in unusual location discussed.

Discussion by Einar Eiskamp, M.D., Watsonville; Walter A. Bayley, M.D., Los Angeles.

20. *Actinomycosis in Association with Appendicitis and Ruptured Viscus*—W. Wallace Greene, M.D., and Carleton Mathewson, Jr., M.D., San Francisco Hospital, San Francisco.

A review of the mode of infection, clinical picture, and pathology of actinomycosis following acute suppurative appendicitis and ruptured viscus; presentation of cases and recommendations for treatment.

Discussion by Leon Goldman, M.D., San Francisco; Thomas A. Card, M.D., Riverside.

Second Meeting—Crystal Room

Tuesday, May 10, 8:30 a.m.

21. *Address by Chairman*—Harlan Shoemaker, M.D., 1930 Wilshire Boulevard, Los Angeles.

22. *Regional Anesthesia in the Acute Abdomen*—E. C. Moore, M.D., 511 South Bonnie Brae Street, Los Angeles.

Less shock to patients; less manipulation; less spreading of infection and much less mortality thereby.

Discussion by Verne C. Hunt, M.D., Los Angeles; Whitfield Crane, M.D., Oakland.

23. *Anomalies of the Colon*—W. H. Brownfield, M.D., 2007 Wilshire Boulevard, Los Angeles.

Cause symptoms of other visceral pathological changes. A plea for generous incision and thorough exploration. The commonly called chronic appendix is usually but a part in the process of cecal "immobilization." Extention of the linea terminalis may be responsible for condition of frequently called fixed sigmoid colon. The incidence of diverticulosis and diverticulitis. The various herniations are not discussed.

Discussion by John C. Schmoele, M.D., Los Angeles; Caleb Stone, M.D., Santa Barbara.

24. *The Problem of Multiple Polyposis of the Colon*—Robert Scarborough, M.D., Stanford Hospital, Clay and Webster Streets, San Francisco.

Multiple polyposis of the colon, either hereditary ("primary diffuse polyposis") or secondary to an inflammatory process in the colon ("pseudopolyposis") presents a critical problem to the surgeon. Eradication of all polyps is essential to prevent almost inevitable malignant degeneration. To this end radical surgery alone has been shown to be effective. Three successful cases of excision of the entire colon and rectum are described.

Discussion by William Daniel, M.D., Los Angeles; Fred Foote, M.D., San Francisco.

25. *Colectomy, Complete*—Alanson Weeks, M.D., and G. D. Delprat, M.D., Fitzhugh Building, San Francisco.

Experience with three patients. Three patients are presented in which a complete colectomy is performed. The first for pseudopolyposis, and ulceration of the colon. The other two cases for ulceration, fistula formation, and marked toxemia.

Discussion by A. C. Reed, M.D., San Francisco; Malcolm Hill, M.D., Los Angeles.

26. *Obstruction Following Gastro-enterostomy or Subtotal Resection of the Stomach—A New and Simple Operation for Its Relief*—Carl L. Hoag, M.D., 384 Post Street, San Francisco, and John B. deC. M. Saunders, F.R.C.S. (Ed.), University of California Hospital, San Francisco (by invitation).

Early obstruction following gastro-enterostomy or subtotal resection of the stomach occurs in a comparatively small percentage of cases, but when it does happen it is a serious and frequently fatal condition. If the obstruction persists after seven to ten days of conservative treatment or occurs late in the period of convalescence, it is usually mechanical in character so that an emergency operation becomes imperative, with a resulting mortality of approximately 75 per cent.

The authors have devised a jejunoplasty, based upon the principles of the Finney pyloroplasty, which

* Monitors: Carleton Mathewson, M. D., San Francisco. and Omer Wheeler, M. D., Riverside.

requires a minimum of surgery and gives the same excellent relief. This jejunoplasty is of value not only in relieving the acute obstruction, but it permits visual inspection of the stoma and may be used in chronic cases as an approach, (1) for cauterization or excision of a marginal or jejunal ulcer; (2) to increase the size of the gastric stoma if it is too small; and (3) to completely close the gastric stoma in those cases where restoration of the original continuity of the gut is desired.

Report of cases. Illustration by lantern slides and charts. Report of animal experimentation. Exhibit of museum specimens.

Business Recess

Business meeting and election of officers.

❦

Third Meeting—Crystal Room

Wednesday, May 11, 8:30 a. m.

27. *The Surgical Importance of Papaverin Hydrochlorid*—Donald C. Collins, M.D., 1930 Wilshire Boulevard, Los Angeles.

The alkaloid papaverin should be in the armamentarium of every surgeon. The administration of this drug intravenously has saved over 90 per cent of individuals with recent severe massive postoperative pulmonary embolism. The intra-arterial injection has obviated the necessity of an embolectomy in 84 per cent of those suffering from emboli of the peripheral circulation.

Discussion by Donald A. Charnock, M.D., Los Angeles; Stanley H. Mentzer, M.D., San Francisco.

28. *Muscle Grafts in Surgery of Heart and Lung*—Brodie Stephens, M.D., and Harry Benteen, M.D. (by invitation), 384 Post Street, San Francisco.

Fourteen dogs have had bilateral ligation (in stages) of both the right and left coronary arteries. The pectoral muscle has been employed as a graft in an effort to provide an adequate blood supply to the heart in the animals so treated. These animals have now been observed fourteen to eighteen months. A report of the fate of these grafts amplified with injection preparations will be presented. In humans, muscle grafts have also been used in the closure of lung abscess cavities. The fate of these grafts, too, will be demonstrated by both gross and histologic demonstrations.

Discussion by Paul C. Sampson, M.D., Oakland; Albert H. Elliott, Jr., M.D., Santa Barbara.

29. *Transpleural Repair of Traumatic Diaphragmatic Hernia*—H. E. Schiffbauer, M.D., 1005 Brockman Building, Los Angeles.

A report of six cases, with slides and motion pictures in color.

With the increase in injuries from automobile accidents, the incident of traumatic rupture of the diaphragm has increased, and is more often diagnosed. Routine roentgenological examination of the chest is often not sufficient to make the diagnosis. Treatment consists of a reposition of the viscera, repair of hernia by abdominal or transpleural route.

Discussion by Emile Holman, M. D., San Francisco; Clarence G. Toland, M. D., Los Angeles.

30. *Report of Follow-up and Evaluation of the Injection Treatment of Hernia*—Franklin I. Harris, M. D., 450 Sutter Street, San Francisco, and A. S. White, M.D., 516 Sutter Street, San Francisco.

This follow-up study is by request of the chairman of the 1937 Del Monte meeting; a continuation of the report rendered the Society at the 1937 meeting concerning the cases presented at the 1936 meeting in Coronado.

Open to discussion from the floor.

31. *Venereal Lymphogranuloma in California*—Carleton Mathewson, Jr., M.D., San Francisco Hospital.

This report was requested by the chairman of the 1937 session held at Del Monte.

Fourth Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose, and Throat; Pathology; Pediatrics.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 12.)

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Fifth Meeting—Crystal Room

Thursday, May 12, 9:00 a. m.

32. *Burn Contractures of the Hand: Their Prevention and Correction by Means of Skin Grafting*—Harry Blackfield, M.D., 350 Post Street, San Francisco.

A detailed discussion of the types of skin grafts used for hand-surface reconstruction following burns is included in this paper. Lantern slides will be shown, illustrating progressive stages of the grafting in early and late cases, and the results achieved.

Discussion by William Kiskadden, M. D., Los Angeles; Gerald B. O'Connor, M. D., San Francisco.

33. *Nerve Grafts*—Sterling Bunnell, M.D., and Joseph H. Boyes, M.D., 516 Sutter Street, San Francisco.

A note of skepticism pervades the literature concerning nerve grafts which is not warranted by clinical experiences based upon thirty-one cases. The indications for the use of nerve grafts are considered, and regeneration through both undegenerated and degenerated free nerve grafts in experimental animals is shown by photomicrographs. The end-results of thirty-one cases of free nerve grafts in humans are shown graphically on lantern slides.

Discussion by Carl Rand, M. D., Los Angeles; Edmund J. Morrissey, M.D., San Francisco.

34. *Spontaneous Hematoma Occurring in the Rectus Muscle*—H. Glenn Bell, M.D., and Harry Benteen, M.D. (by invitation), University of California Hospital, San Francisco.

The recognition, diagnosis, and treatment of this condition are discussed and a report of cases is given. An etiological classification is offered.

Discussion by Ray B. McCarty, M.D., Riverside, and Edgar L. Gilcreest, M.D., San Francisco.

35. *The Treatment of Cancer of the Lip*—Report of 160 cases from 1932 to 1937, inclusive—George Stevenson Sharp, M.D., 605 Professional Building, Pasadena.

One hundred and sixty cancers of the lip with positive pathological reports are discussed. The treatment of the primary growth is performed advantageously by radiation or surgery or both according to the clinical and microscopical type of cancer. The secondary or metastatic growth in the neck is treated by radical surgery. The clinical types of lip cancer, the procedures of treatment and results are demonstrated by lantern slides.

Discussion by Alson R. Kilgore, M.D., San Francisco, and George D. Brown, M.D., Pomona.

36. *Benign Tumors of Female Breasts*—Franklyn D. Hankins, M.D., 3616 Main Street, Riverside.

The normal anatomy and physiology of the female breast will be briefly reviewed. Alterations of the normal physiology will be discussed in relation to the production of the various pathologic states, namely, (1) mazoplasia, (*a*) fibro-adenoma; (2) cystic disease; (3) papilloma; (4) Schimmelbusch's disease. The symptoms, diagnosis, and treatment and their relation to malignant tumors will be described.

Discussion by Edward M. Butt, M.D., Los Angeles; Nelson J. Howard, M.D., San Francisco.

III

OBSTETRICS AND GYNECOLOGY SECTION*

R. Glenn Craig, M.D., *Chairman*
Medico-Dental Building
490 Post Street, San Francisco

George W. Coon, M.D., *Vice-Chairman*
3770 Twelfth Street, Riverside

John N. Ewer, M.D., *Secretary*
411 Thirtieth Street, Oakland

First Meeting—Tap Room

Monday, May 9, 1:30 p. m.

37. *Squamous Cell Epithelioma of the Vulva*—Edward J. Kilfoy, M.D., 1930 Wilshire Boulevard, Los Angeles.

This paper consists of a review of the literature, anatomy, pathology, the diagnosis, the differential diagnosis, and surgical treatment. The value of x-ray and radium therapy. The radical surgical procedure to be carried out, with an analysis of fifty cases, as regards age incidence, degree of malignancy, type of treatments used, and the prognosis as regards longevity. Illustrated by lantern slides.

Discussion by James Percy, M.D., Los Angeles.

38. *The Use of Sulphanilamid in Lower Genital Tract Gonorrhea*—Arnold Manor, M. D., 2355 California Street, San Francisco.

This paper concerns briefly the use of sulfanilamid in the treatment of gonorrhea in the Women's Out-Patient Clinic at Stanford University Hospital, and the results obtained.

Discussion by Norman H. Williams, M.D., Los Angeles.

39. *The Use of Sulphanilamid in Upper Genital Tract Gonorrhea*—Raymond E. Gillett, M.D., (by invitation), 2635 Twenty-Third Street, San Francisco.

Discussion of dosage; clinical therapeutic results obtained with sulphanilamid in (*a*) initial acute salpingo-oöphoritis, (*b*) recurrent acute salpingo-oöphoritis, and (*c*) acute parametritis; the value of this drug in the treatment of cervicitis; toxic complications during medication; deductions.

Discussion by Henry N. Shaw, M.D., Los Angeles; Roy E. Fallas, M.D., Los Angeles; and Norman H. Williams, M.D., Los Angeles.

40. *Gonorrheal Vulvovaginitis in Childhood*—Woodburn K. Lamb, M.D., 2490 Channing Way, Berkeley.

This study presents a series of twenty-three patients studied at the University of Michigan Hospital, with vulvovaginitis of gonorrheal etiology. The physiology concerned in this disease entity is discussed, and slides to demonstrate the changes are presented. Treatment in the twenty-three cases consisted of estrogenic hormone (Theelin) given intramuscularly. In all the cases studied, a positive urethral and vaginal smear was found. The potentialities of the urethra as a focus of reinfection discussed, and the need for careful study stressed.

Discussion by Bernard J. Hanley, M. D., Los Angeles.

41. *Renal Changes Following Toxemias of Late Pregnancy*—Ernest W. Page, M.D., 2560 Bancroft Way, Berkeley, and Alvin J. Cox, M. D., 1905 Laguna Avenue, San Francisco.

A study based on the histologic findings of kidneys from women who have had toxemias of late pregnancy, compared with those from women who have had pregnancies, but no evidence of toxemia. The results are interpreted with the aid of clinical follow-up studies on ninety cases of eclampsia.

Discussion by Lyle G. McNeile, M. D., Los Angeles, and Dwight L. Wilbur, M.D., San Francisco.

* Monitors: Dwight D. Young, M. D., Los Angeles, and James V. Campbell, M. D., Oakland.

Second Meeting—Tap Room

Wednesday, May 11, 8:30 a. m.

42. *Varicose Veins in Pregnancy*—A. M. McCausland, M.D., 3780 Wilshire Boulevard, Los Angeles.

This paper is a preliminary report of the history, treatment, and follow-up examinations of 150 pregnant women, whose varicose veins were cared for at the Los Angeles Maternity Service. Special attention will be given to the treatment of vulvar varicosities. A very short review of the literature on this subject will be included. Slides will be used in presenting the material and in demonstrating the technique used.

Discussion by Nelson J. Howard, M.D., San Francisco.

43. *Induction of Labor*—William Benbow Thompson, M.D., 803 Wilshire Medical Building, Los Angeles.

Within the past few years there have appeared numerous enthusiastic publications advocating induction of labor by means of rupture of membranes accompanied by preliminary castor oil and quinin medication and usually followed by Intranasal Pituitary Extract. As should have been expected, the procedure has been adopted by many with insufficient experience in obstetrics in general and, as a consequence, often the results have been highly unsatisfactory for both mother and child. In general, the failure in induction has occurred because the condition of the cervix has not been recognized. In other instances an unfavorable position of the infant has resulted disastrously. A review of the patients upon whom induction has been performed, gathered from two of the local hospitals, and, in addition, a questionnaire covering the experience of the members of the Pacific Coast Obstetrical Society, forms the basis of this study.

Discussion by Donald Tollefson, M. D., Los Angeles.

44. *Chairman's Address: The Specialty of Gynecology*—R. Glenn Craig, M.D., 490 Post Street, San Francisco.

The scope of gynecology. Its development. A consideration of the anthropological, psychological, and endocrinological characteristics of the female. The importance of these in the selection, application and evaluation of surgical procedures.

45. *The Relation of Estrogenic and Gonadotropic Hormones to Climacteric Symptoms*—Kathleen M. Murphy, M.D., 516 Sutter Street, San Francisco, and C. F. Fluhmann, M.D., Stanford University Hospital, San Francisco.

The recent literature tends to attribute the subjective symptoms of the climacteric to either the loss of ovarian secretion or increase of anterior pituitary hormone. The present study is an analysis of the hormone content of the blood of climacteric women before and after the menopause, and its relation to the patients' symptoms.

Discussion by John C. Irwin, M.D., Los Angeles.

46. *Roentgen-Ray Therapy for Uterine Cancer*—Daniel G. Morton, M.D., University of California Hospital, San Francisco.

An effort is made to assay the value of high voltage roentgen-ray therapy for uterine cancer as reflected by the results obtained during the last six years at the University of California Hospital on cases in which deep roentgen-ray therapy was used. Survival curves are compared with those obtained in comparable cases not so treated. The morbidity and mortality of roentgen radiation is discussed.

Discussion by Robert Stone, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

Third Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose and Throat; Pathology; Pediatrics.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 12.)

IV

EYE, EAR, NOSE, AND THROAT SECTION*

FRANK BAXTER, M.D., *Chairman*
1624 Franklin Street, Oakland

DEWEY R. POWELL, M.D., *Vice-Chairman*
Medico-Dental Building, Stockton

CLIFFORD W. WALKER, M.D., *Secretary*
427 West Seventh Street, Los Angeles

First Meeting—Cottage "A"

Monday, May 9, 1:30 p. m.

47. *The Equipment of the Modern Oculist's Office*—George Hosford, M. D., 450 Sutter Building, San Francisco.

Relation of economic pressure to present-day trends in medical and surgical practice. Methods of meeting conditions which are developing. Organization of an ophthalmological office. Climatic considerations and location of building. Floor plans and routing of patients. Waiting rooms, treatment rooms, operating room, homatropin room, field room, refraction charts and equipment, slitlamps, control of illumination.

Discussion by Clifford W. Walker, M. D., Los Angeles; Samuel Durr, M. D., San Diego.

48. *The Surgical Management of Otogenous Brain Abscess*—Leo J. Adelstein, M.D., 1930 Wilshire Boulevard, Los Angeles.

The surgical management of otogenous brain abscess includes: (1) The exact diagnosis and localization by neurologic study. (2) An optimum period of observation to allow the infectious process to thoroughly encapsulate. (3) Surgical drainage by the simplest possible method and adequately maintained for at least six weeks or longer. The method of drainage by choice is the one that permits adequate and prolonged drainage with the least amount of post-operative interference on the part of the operator.

Discussion by George H. Patterson, M. D., Los Angeles; Simon Jesberg, M. D., Los Angeles.

49. *Progressive Essential Atrophy of Iris—A Summary of All Reported Cases*—Etta C. Jeancon, M.D., 523 West Sixth Street, Los Angeles.

Progress of a case which has been under observation for six years. All reported cases (about thirty), compared and studied with especial regard to their final outcome, most of which ended in blindness in the affected eye.

Discussion by Hans Barkan, M. D., San Francisco; George Landegger, M. D., Los Angeles.

50. *The Prognosis in Sarcoma of the Uveal Tract*—M. N. Beigelman, M. D., 1930 Wilshire Boulevard, Los Angeles.

The relative incidence of recurrence and metastases in various clinical stages of the disease. The prognostic value of histologic structure in cases of uveal sarcoma, based on (1) the presence or absence of pigment; (2) the type of cells; (3) the distribution of reticular fibers. Statistical illustrations.

Discussion by Hans Barkan, M. D., San Francisco; H. G. Merrill, M. D., San Diego.

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Second Meeting—Cottage "A"

Tuesday, May 10, 8:30 a. m.

51. *The Endonasal Tear Sac Operation*—Ben L. Bryant, M. D., 2007 Wilshire Boulevard, Los Angeles.

The various surgical procedures which have been used in the past for the treatment of chronic dacryocystitis are considered, and their respective advantages and disadvantages evaluated. A modified endonasal operation is described, with emphasis placed on those factors which are of greatest influence on the final result, stress being placed on the physiology of the region. The results of a series of cases treated by this method are presented.

Discussion by George P. Landegger, M. D., Los Angeles; John P. Lordan, M. D., Los Angeles.

52. *Exfoliation of the Lens Capsule: Frequency of Occurrence and Significance*—Rodman Irvine, M. D., 700 Roosevelt Building, Los Angeles.

Two hundred and thirty-five cataract patients seen consecutively at the Government Eye Hospital at Madras, India, were examined for exfoliation of the lens capsule. The condition was found in eight per cent of the cases. Of those with exfoliation, 50 per cent had chronic glaucoma. Twenty cases seen in this country were followed and showed an incidence of glaucoma of 75 per cent. The prognosis for these cases is less favorable than for other cataract cases, generally speaking. The relation of senile exfoliation of the lens capsule to zonular lamellar separation, as seen in heat cataract, is discussed with an attempt to explain the etiology of exfoliation.

Discussion by Clinton Wilson, M.D., and George Landegger, M.D.

52a. *Treatment of Sinusitis by the Displacement Method*—Lawrence K. Gundrum, M.D., 1930 Wilshire Boulevard, Los Angeles.

Report of eight hundred cases using ephedrin, neosynephrin, antigen, and foreign proteins.

The cases reported in this paper comprise a study conducted during the past ten years. The discussion is limited to chronic sinusitis. Eight hundred cases are presented with symptoms, findings and results, with treatments. The displacement treatment was used in all cases. One hundred and eighty treated, using ephedrin or neosynerphrin in normal saline; twenty using autogenous bacterial antigen; five hundred using stock antigens; and one hundred with foreign proteins (broth media). The results were most favorable when stock antigens were used.

Discussion by Herman Semenov, M.D., Los Angeles, and Mathew N. Hosmer, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

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Third Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose and Throat; Pathology; Pediatrics.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 12.)

* Monitors: Dewey Powell, M.D., Stockton, and Rodman Irvine, Los Angeles.

V

ANESTHESIOLOGY SECTION*

WILLIAM LEROY GARTH, M.D., *Chairman*
1252 Third Avenue, San Diego

JOHN G. DUNLOP, M.D., *Secretary*
168 So. Kingsley Drive, Los Angeles

First Meeting—Cottage "F"

Monday, May 9, 1:30 p. m.

53. *Chairman's Address: Anesthesia in Europe*—William L. Garth, M. D., 1252 Third Avenue, San Diego.

54. *Present Status of Inhalation Anesthesia for Tonsillectomy with Special Technique when Pulmonary or Renal Complications Exist*—R. G. Henderson, M. D., 1101 Security Building, Long Beach.

Inhalation anesthesia for tonsillectomy is a procedure which requires careful technique and involves much responsibility. Preoperative medication is discussed together with routine methods of anesthesia, using gas and ether vapor. Pulmonary and kidney complications contraindicate the use of ether, and endotracheal cyclopropane is recommended as a desirable alternative method.

Discussion by C. E. Harner, M. D., Long Beach; W. W. Hutchinson, M. D., Los Angeles.

55. *On Respiration*—Arthur E. Guedel, M.D., 1633 Wellington Road, Los Angeles.

Stimulus threshold a variable factor. Response to stimulus depends upon relationship between stimulus and threshold. Anesthetic respiration affords easiest illustration.

Discussion by Clinton Thienes, M.D., Los Angeles.

56. *Experimental Basis for the Use of Stimulants*—Clinton H. Thienes, M. D., 3551 University Avenue, Los Angeles.

Analeptics are drugs that antagonize a state of depression. Drugs may arouse a comatose patient, or simply increase respirations or stimulate the vasomotor centers. The principal drugs of this sort are caffein, theophyllin, strychnin, metrazol, pictrotoxin, coramin, lobelin, and benzedrin. Peripherally acting drugs are the digitaloid glucosides and the sympathomimetic amins. The experimental basis for the clinical use of these drugs will be discussed.

Discussion by Albert J. Wineland, M. D., Los Angeles, and Myron Prinzmetal, M.D., Los Angeles (by invitation).

57. *The Desirability of a Selective Anesthetic Program*—Hall G. Holder, M. D., 233 A Street, San Diego.

Knowledge of the recent advances in anesthesia afford the surgeon considerable choice in selecting the anesthetic best suited for the surgical problem at hand. This choice must also take into consideration physical and emotional handicaps. This paper will discuss these and related problems.

Discussion by George D. Huff, M.D., San Diego; Edwin H. Kelley, M.D., San Diego.

Business Recess

Business meeting and election of officers.

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Second Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

Section unites with other Sections for symposium on "Shock" in main ballroom. (See page 12.)

* Monitors: Madeline Manuel, M.D., Pasadena; J. G. Dunlop, M.D., Los Angeles.

VI

DERMATOLOGY AND SYPHILOLOGY SECTION*

STANLEY O. CHAMBERS, M.D., *Chairman*
Roosevelt Building
727 West Seventh Street, Los Angeles

NELSON PAUL ANDERSON, M.D., *Secretary*
904 Westlake Professional Building
2007 Wilshire Boulevard, Los Angeles

ARNE E. INGELS, M.D., *Assistant Secretary*
Medico-Dental Building
490 Post Street, San Francisco

First Meeting—Cottage "B"

Monday, May 9, 1:30 p. m.

58. *Chairman's Address*—Stanley O. Chambers, M. D., 727 West Seventh Street, Los Angeles.

59. *Lymphoblastomas*—Udo J. Wile, M. D., Professor of Dermatology and Syphilology, University of Michigan, Ann Arbor, Michigan. (By invitation.)

This paper will treat of the lymphoblastomas as they involve the skin. The various dermatologic manifestations of the leukemias, Hodgkin's disease, and mycosis fungoides will be discussed. The relationship of these diseases to each other will be considered. Illustrated by lantern slides.

Discussion by Howard Morrow, M.D., San Francisco; Samuel Ayres, Jr., M.D., Los Angeles.

60. *Signs of Malignancy in Melanomas*—Clement E. Counter, M.D., 206 Professional Building, Long Beach.

This paper will deal with a large group of melanomas of the skin studied histopathologically with special reference to the signs of malignancy, particularly early malignant changes. Illustrated by photomicrographs.

Discussion by Nelson Paul Anderson, M. D., Los Angeles; John W. Budd, M. D., Los Angeles.

61. *Use of Strontium Bromid in Acute Urticaria*—Hiram D. Newton, M. D., 1203 Bank of America Building, San Diego.

This paper consists of a review of the use of strontium bromid in itching dermatoses, with specific reference to its use in acute urticaria and angioneurotic edema. S. Schubert, in 1929, reported eighteen such cases with phenomenal results by the intravenous use of strontium bromid. This report consists of about twenty cases of acute urticaria, urticarial serum reaction and angioneurotic edema treated by the intravenous injection of strontium bromid. An analysis of the results obtained and a discussion of the indications and contra-indication for the use of strontium bromid is included.

Discussion by William H. Goeckermann, M. D., Los Angeles; Laurence Taussig, M. D., San Francisco.

62. *The Uses of Sulfanilamid in Dermatology*—Franklin I. Ball, M. D., 6253 Hollywood Boulevard, Hollywood.

This paper will be a review of the employment of the drug as a therapeutic agent in such dermatoses as erysipelas, streptococcic lymphangitis and cellulitis, and chronic infectious eczematoid dermatitis. This paper will be illustrated with lantern slides in natural color.

Discussion by Arne E. Ingels, M. D., San Francisco; George Koetter, M. D., Los Angeles.

63. *Scabies: Its Treatment with Benzoyl Benzoate as Compared with Sodium Thiosulphate and HCl*—Arne E. Ingels, M. D., 490 Post Street, San Francisco.

A series of about sixty cases treated with benzoyl benzoate, sapomollis and alcohol, on two consecutive days, will be reported, mentioning untoward reactions and advantages; this, compared with an equal number of cases treated with sodium thio-

* Monitors: Thomas W. Nisbet, M. D., Pasadena, and Anker K. Jensen, M. D., Los Angeles.

sulphate and HCl. A short reference to other antiscabetics will also be presented.

Discussion by Harry J. Templeton, M. D., Oakland; Thomas W. Nisbet, M. D., Pasadena.

64. *Pruritus Ani*—Charles R. Caskey, M. D., 1930 Wilshire Boulevard, Los Angeles.

This paper will discuss the subject from a dermatological aspect. Proctological, urological, and constitutional causative factors will be enumerated but left for discussion to specialists in these fields. Local etiological factors will be discussed, followed by pathology and treatment. Personal clinical deductions will be given with little reference to the literature.

Discussion by Philip K. Allen, M.D., San Diego; William H. Daniels, M.D., Los Angeles.

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Second Meeting—Cottage "B"

Tuesday, May 10, 8:30 a. m.

65. *Mapharsen Tolerance in Neoarsphenamin-Sensitive Patients: Analysis of One Hundred Cases*—Katherine H. MacEachern, M. D., 1200 North State Street, Los Angeles. (By invitation.)

This paper is a study of reactions to mapharsen in the treatment of syphilis in patients who previously showed intolerance to neoarsphenamin. Formerly the treatment of such patients was limited to the heavy metals. A certain percentage of these arsphenamin-sensitive patients are able to tolerate mapharsen.

Discussion by Hiram E. Miller, M.D., San Francisco; Frederick G. Novy, Jr., M.D., Oakland.

66. *Studies in Tissue Concentration of Bismuth*—Julius R. Scholtz, M. D., and Albert Cheney, Ph.D. (by invitation), 1930 Wilshire Boulevard, Los Angeles.

This study represents an attempt to show the concentration levels of bismuth which are attained when bismuth is administered in therapeutic doses to human syphilitic subjects. The data presented is from careful chemical analyses of the vital organs of persons who, while under routine bismuth therapy for syphilis, suffered sudden death from other causes. Included are two cases in which the cause of death was acute renal failure due to bismuth nephrosis. None of the other cases showed any clinical evidence of bismuth toxicity. Reports are given on twelve cases; this exceeds by far the total of all cases previously reported in the literature.

Discussion by Clinton Thienes, M.D., Los Angeles; Edward M. Butt, M.D., Los Angeles.

67. *The Absorption and Elimination of Bismuth Following Its Oral Administration to Rabbits*—Ernest K. Stratton, M. D., 490 Post Street, San Francisco.

In a comparative study several oral bismuth preparations were given to rabbits; the bismuth content of the feces and urine was determined following the administration of single doses as well as after multiple daily doses.

Discussion by Udo J. Wile, M. D., Ann Arbor, Michigan; Julius R. Scholtz, M. D., Los Angeles.

68. *The Treatment of Active Interstitial Keratitis in Prenatal Syphilis*—C. Russell Anderson, M. D., 1930 Wilshire Boulevard, Los Angeles.

The treatment of interstitial keratitis by chemotherapy alone is usually disappointing. Means were sought by which quiescence of the process could be brought about, thereby reducing opacities and scarring of the cornea to a minimum. During the past two years, all patients seen in the Los Angeles General Hospital, and all private patients, have been given a course of malaria fever with gratifying results. In some, in which age was a contraindication, typhoid vaccine intravenously was used. The cases are reviewed, and the conclusion is that at the present time malaria is the method of choice in treating active interstitial keratitis.

Discussion by Udo J. Wile, M. D., Ann Arbor, Michigan; Harold F. Whalman, M. D., Los Angeles.

69. *The Ninth-Day Erythema Following Arsphenamin Therapy*—Norman N. Epstein, M. D., and Edward A. Levin, M. D., 450 Sutter Street, San Francisco.

The ninth-day erythema due to arsphenamin therapy is of considerable practical importance in antisyphilitic therapy. Five cases showing this reaction are reported. A discussion, with a review of the literature upon this subject, is presented.

Discussion by Maxwell J. Wolff, M.D., Los Angeles; C. J. Lunsford, M.D., Oakland.

70. *The Nonspecific Provocative Wassermann Reaction*—Charles W. Barnett, M. D., George V. Kulchar, M. D., and Richard B. Jones, M. D., Stanford University Medical School, San Francisco.

In a study of the provocative Wassermann reaction in syphilitic and nonsyphilitic patients, similar effects were noted. The clinical and experimental aspects of the provocative reaction are dealt with, special emphasis being placed on its lack of specificity.

Discussion by Stuart Way, M.D., San Francisco; H. Sutherland Campbell, M.D., Los Angeles.

Business Recess

Business meeting and election of officers.

VII

INDUSTRIAL MEDICINE AND SURGERY SECTION*

Frederic C. Bost, M.D., *Chairman*
384 Post Street, San Francisco

Harvey G. McNeil, M.D., *Vice-Chairman*
523 West Sixth Street, Los Angeles

George H. Sanderson, M.D., *Secretary*
242 North Sutter Street, Stockton

First Meeting—Cottage "D"

Monday, May 9, 1:30 p. m.

71. *Chairman's Address: The Importance of the Emergency Treatment of Compound Fractures*—Frederic C. Bost, M.D., 384 Post Street, San Francisco.

72. *Announcements Regarding Statistical Data on Industrial Accident Practice in the State of California*—Morton R. Gibbons, M. D., 350 Post Street, San Francisco.

73. *Neuropathic Joints: A Study of Their Development, with Particular Emphasis on the Causative Rôle of Trauma. Suggestions for Conservative and Radical Orthopedic Treatment*—Ralph Soto-Hall, M. D., 350 Post Strect, San Francisco, and Keene O. Haldeman, M. D., 350 Post Street, San Francisco.

A group of neuro-arthropathies (Charcot joints) have been studied to determine their manner of development and their relation to trauma. Emphasis has been placed on the very early changes when the diagnostic problems are difficult. In addition to suggestions for conservative treatment, a method of arthrodesis of neuropathic joints, not previously reported, is described. This operation is performed in two stages, the first of which makes the sclerotic bone more viable by revascularization through multiple drilling, which procedure is followed by the arthrodesing operation.

Discussion by Ernst Freund, M.D., Los Angeles; Donald McNeil, M.D., Sacramento.

Business Recess

Business meeting and election of officers.

* Monitors: Mosser Taylor, M.D., Los Angeles, and William Arthur Clark, M.D., Pasadena.

74. *Traumatic Appendicitis*—George K. Rhodes, M. D., 490 Post Street, San Francisco.

Traumatic appendicitis is a diagnosis infrequently made but, nevertheless, one over which there is much controversy. Many claim awards have been made on the basis of such a diagnosis. This subject will be reviewed and the author's personal experience with several cases summarized.

Discussion by Wayland Morrison, M. D., Los Angeles; R. A. Jewett, M. D., Los Angeles.

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Second Meeting—Cottage "C"

Tuesday, May 10, 8:30 a. m.

This will be a joint meeting of the Section on Radiology and the Section on Industrial Medicine and Surgery.

The program of this joint meeting is printed under the first meeting of the Radiology Section. (See page 22.)

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Third Meeting—Crystal Room

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON NUCLEUS PULPOSUS RUPTURE AND ITS RELATION TO INJURY

75. *Neurosurgical Aspects*—Howard Brown, M. D., 384 Post Street, San Francisco.

A consideration of the antomy; clinical history and findings. Diagnoses by lipiodol studies. Use of intraspinal air as a diagnostic measure. Operative findings and results.

76. *Orthopedic Aspects, Including the Question of Spinal Fusion Following Laminectomy*—Frederick Linde, M. D., 490 Post Street, San Francisco.

The following is a short résumé indicating the salient points in my paper on spinal fusion following laminectomy; (1) Orthopedic aspects of symptoms referable to dislocated intervertebral discs; (2) The desirability of a spinal fusion following complete laminectomy; (3) Technique of operation; (4) Postoperative care and results.

77. *X-ray Aspects*—Kenneth S. Davis, M.D., 2131 Ocean View Boulevard, Los Angeles.

The recognition by Mixter, Barr, and Ayres that protrusions of the intervertebral discs were identical with the lesions described by Schmorl has stimulated great interest in this condition. The roentgenographic signs may be classified as direct and indirect. The *direct* signs (narrowing to the intervertebral space, hypertrophic lipping, etc.), while suggestive, do not justify one in making a positive diagnosis. The indirect signs are obtained either by air myelography or by the use of lipiodol. Lipiodol should only be used in carefully selected cases after a thorough clinical investigation by one competent in doing neurological examination. It should never be used without a preliminary Queckenstedt test, and an examination of the spinal fluid.

78. *The Viewpoint of the Insurance Carrier and Claims Attorney*—Edmund D. Leonard, Esq., Attorney, San Francisco. (By invitation.)

79. *The Present Attitude of the Industrial Accident Commission*—Ross Harbaugh, M. D., 350 Post Street, San Francisco.

Discussion by Carl Rand, M. D., Los Angeles; J. M. Robinson, M. D., San Francisco.

A discussion of cases which have come before the Industrial Accident Commission with diagnosis, treatment, and degree of disability resulting.

VIII

NEUROPSYCHIATRY SECTION*

Fred O. Butler, M.D., *Chairman*
Sonoma State Home, Eldridge

John B. Doyle, M.D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

First Meeting—Tap Room

Tuesday, May 10, 8:30 a. m.

80. *Chairman's Address: The Importance of a State-Wide Program on Mental Hygiene in California*—F. O. Butler, M. D., Sonoma State Home, Eldridge.

While much has been done on general preventive medicine in the State and country, comparatively little has been done on a broad scale along mental lines. A very definite program should be set up in California, especially on account of the big influx of all types of mental cases, which thus far the State has been unable to control.

81. *Geriatric Psychiatry—A Review of Some of the Psychiatric Problems of Senescence*—Charles Lewis Allen, M.D., 214 South Lafayette Park Place, Los Angeles.

Increase in the number of old people being brought to our Psychopathic Hospital. The cause of this increase. The nature of senescence and its physical basis. An outline of the chief psychopathic manifestations observed in our material. What can be included under the subject of psychoses of senescence? Their etiology, pathology, diagnosis, and classifications. Their prognosis and treatment. Complication of this latter problem by the California laws. Medico-legal considerations with regard to the senile psychoses.

Discussion by Paul A. Gliebe, M. D., San Francisco; Verne R. Mason, M. D., Los Angeles.

82. *Insulin Shock Therapy in Dementia Praecox: A Report of a Series of Cases*—Clifford W. Mack, M.D., Livermore Sanitarium, Livermore.

Introduction. Selection of cases. Legal complications. Points to be discussed with the family concerning the dangers and possibilities of treatment. Methods of treatment used. Number of cases. Brief case reports giving duration, symptoms, degree of mental impairment and results of treatment. Conclusion and analysis of results. Psychiatric lessons to be learned from this method of treatment.

Discussion by J. M. Nielson, M.D., Los Angeles; G. S. Johnson, M.D., San Francisco.

83. *Suicide*—F. G. Lindemulder, M. D., 2001 Fourth Avenue, San Diego, and F. E. Toomey, M. D., 233 A Street, San Diego.

It is an established fact that San Diego has the highest suicide mortality in the Western Hemisphere. This study includes research into probable causes of suicide from psychiatric, sociologic, and meteorologic standpoints. An attempt to classify the cases, separately and collectively, to gain more insight into the causation of suicide in this particular location is made.

Discussion by A. J. Rosanoff, M.D., and Glenn E. Myers, M.D., Los Angeles.

84. *An Analysis of the Classification "Epileptic Psychosis"*—Eugene Ziskind, M.D., and Esther Somerfeld-Ziskind, M.D., 2007 Wilshire Boulevard, Los Angeles.

The different types of psychotic reaction seen in epileptics are examined. The point is raised that epilepsy is a symptom or syndrome. The validity of making a major classification of the psychoses dependent on a symptom is questioned. Many epileptic psychoses are identical with psychoses caused by known etiologic agents. Only in the absence of a

* Monitors: Karl O. von Hagen, M. D., Los Angeles, and Cullen W. Irish, M. D., Los Angeles.

known etiologic factor is the condition referred to as an epileptic psychosis. The bearing of repeated convulsions on the possible production of a psychosis is discussed.

Discussion by G. S. Johnson, M. D., San Francisco; William Edler, M. D., Pasadena.

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Second Meeting—Cottage "B"

Wednesday, May 11, 1:30 p. m.

85. *Sympathectomy in Angina Pectoris*—R. B. Raney M.D., 727 West Seventh Street, Los Angeles.

A discussion of the cause of symptoms in angina pectoris, with especial attention to their relationship to the autonomic nervous system. The psychologic action of therapeutic drugs is taken up, as well as experimental work on the sympathetic nerve supply to the coronary vessels. An attempt is made to establish a basis for rational surgical therapy. A new operation is described. Five patients have been operated by this method; all obtained complete relief. One of the five gave definite electrocardiographic evidence of coronary disease.

Discussion by D. G. Dickerson, M. D., Los Angeles; Carl W. Rand, M.D., Los Angeles.

86. *Traumatic Intracerebral Hemorrhage: Its Relationship to Delayed Traumatic Apoplexy*—C. B. Courville, M. D., 312 North Boyle Avenue, Los Angeles.

Intracerebral hemorrhage following injury to the head is not uncommon. Judging from its anatomic location, it is probably a contrecoup lesion. On the basis of pathologic evidence, it is doubtful whether the so-called delayed traumatic apoplexy has any etiologic relationship to craniocerebral injury.

Discussion by H. W. Flemming, M.D., San Francisco; R. B. Raney, M.D., Los Angeles.

87. *Contributory Factors in Vascular Encephalopathy*—C. W. Irish, M. D., 1930 Wilshire Boulevard, Los Angeles.

In addition to a general discussion a number of photographs of illustrative lesions, photographs in color of injected specimens and photographs of roentgenologic studies of the cerebral supply will be demonstrated.

Discussion by A. G. Foord, M. D., Pasadena; W. N. Anderson, M. D., Los Angeles.

88. *Relation of the Childhood Infections to Behavior*—Arthur R. Timme, M.D., 1930 Wilshire Boulevard, Los Angeles.

Many behavior difficulties encountered in children have their root in what appears to be a mild encephalitis during the course of one of the infectious diseases. The prototype of this sort of behavior is seen in behavior changes in children following epidemic encephalitis, though usually to a greater degree. The grouping of symptoms is typical enough to be called a syndrome. Central nervous, vegetative nervous and endocrine symptoms are the rule. Localization in the hypothalmic region and basal ganglia is indicated.

Discussion by F. N. Anderson, M. D., Los Angeles; S. J. Glass, M. D., Los Angeles.

89. *Unilateral Cerebral Dominance: A Consideration of Some of Its Manifestations*—Karl O. von Hagen, M.D., 727 West Seventh Street, Los Angeles.

The different parts of the brain are discussed with regard to laterality of function. The degree of unilateral cerebral dominance varies for different functions and in different individuals. For some functions it is complete; for others only relative; while for others no dominance is evident. Recent advances of knowledge on the subject.

Discussion by F. G. Lindemulder, M. D., San Diego; S. D. Ingham, M. D., Los Angeles.

Business Recess

Business meeting and election of officers.

IX

PATHOLOGY AND BACTERIOLOGY SECTION*

Gertrude Moore, M.D., *Chairman*
2404 Broadway, Oakland

George D. Maner, M.D., *Secretary*
657 South Westlake Boulevard, Los Angeles

Paul H. Guttman, M.D., *Assistant Secretary*
1127 Eleventh Street, Sacramento

First Meeting—Cottage "E"

Monday, May 9, 1:30 p. m.

90. *Chairman's Address*—Gertrude Moore, M. D., 2404 Broadway, Oakland.

91. *Bilateral Carcinoma of the Breast, with an Interesting Familial History*—David A. Wood, M. D., Stanford University School of Medicine, San Francisco; E. L. Rixford, M. D., 1795 California Street, San Francisco; and H. H. Darling, M. D., 909 Hyde Street, San Francisco.

This is the report of a typical cancer family in which most of the members of three generations have either succumbed to cancer or are suffering with it at the present time. On both sides of the family tree bilateral carcinoma of the breast has appeared.

92. *Some Bacteriological Studies in Sulphanilamid Therapy*—Paul Michael, M. D., 434 Thirtieth Street, Oakland.

This paper confines itself to a review of the pertinent literature only. The biochemical and physiological reactions of sulphanilamid and its allied substances are discussed. Bacteriological studies *in vivo* and *in vitro* reported, with particular reference to the gonococcus, staphylococcus and streptococcus groups. Rationale of improved method of therapy discussed.

93. *Intracranial Vascular Anomalies—Pathology of Certain Congenital and Acquired Lesions of Intracranial Blood Vessels*—Newton Evans, M. D., 2000 Milan, South Pasadena, and Cyril B. Courville, M. D., 312 South Boyle Avenue, Los Angeles.

In an autopsy series of approximately twenty thousand, a large number of these vascular anomalies have been encountered. These include aneurysms of the circle of Willis and its branches, varices of the dural sinuses, angiomas, angioblastomas, etc. These are discussed from the standpoint of pathogenesis, morphology and effects.

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Second Meeting—Cottage "D"

Tuesday, May 10, 8:30 a. m.

94. *Aplastic Anemia: Some Little-Stressed Aspects*—Theodore S. Kimball, M. D., 217 North Central Avenue, Glendale; and Sydney N. Soll, M. D. (by invitation), 2423 Grand Street, Huntington Park.

Aplastic anemia has been usually thought of as a condition in which the severe leukopenia, anemia, and thrombopenia present are the result of a completely aplastic bone marrow. In a series of cases recently autopsied at the Los Angeles County Hospital studies have revealed that the above clinical findings may result from bone marrow which still contains many regenerating cells.

95. *Morphology of Epithelioblastoma*—John W. Budd, Jr., M. D., 2131 West Third Street, Los Angeles.

In an analysis of salivary gland tumors the wide variety of tumor patterns was found to be due to variations in (1) degree in direction of differentiation of the epithelial cells; (2) polarity of secretion; (3) nature of secreted material.

Other forms of epithelial neoplasms are similarly analyzed.

* Monitors: T. S. Kimball, M. D., Los Angeles, and E. M. Butt, M. D., Los Angeles.

96. *Report of an Epidemic of Gastro-enteritis in Infants*—E. M. Butt, M.D., 3551 University Avenue, Los Angeles; and John F. Kessell, Ph.D. (by invitation), University of Southern California School of Medicine, Los Angeles.

This paper will include a summary of the case histories, the necropsy findings, and a report of the bacteriological studies in a series of four cases of gastro-enteritis together with pneumonia in infants. These infants simultaneously contracted the infection during their first few days of life in a local maternity hospital. The epidemic subsided as abruptly as it began and no further cases developed. Pseudomonas aeruginosa was recovered from all four cases. The evaluation of these findings will be discussed in detail in the paper.

97. *Tuberculosis of Animal Origin*—Emil Bogen, M.D., Olive View Sanatorium, San Fernando.

Nearly two thousand reported instances of bovine type tubercle bacillus infection in man emphasize the importance of transmission from animals. An instance of pulmonary tuberculosis of bovine origin discovered at Olive View illustrates this danger. Tuberculosis of animal origin should be eradicated.

98. *Theca Cell Tumors of the Ovary*—A. G. Foord, M.D., 749 Fairmont Avenue, Pasadena.

A report of two cases of theca cell tumors will be given, with discussion of the cases in the literature, aggregating about seventeen at the present time. For years these cases have been classed as ovarian fibromas or some other term. The similarity of the clinical manifestations to those of granulosa cell tumors and the embryologic and histologic diagnostic features will be discussed.

Business Recess

Business meeting and election of officers.

Third Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose and Throat; Pathology; Pediatrics.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 12.)

X

PEDIATRICS SECTION*

E. Earl Moody, M.D., *Chairman*
829 So. Alvarado Street, Los Angeles

Hartzell H. Ray, M.D., *Secretary*
23 Second Avenue, San Mateo

W. W. Belford, M.D., *Assistant Secretary*
601 Medico-Dental Building, San Diego

First Meeting—Cottage "C"

Monday, May 9, 1:30 p. m.

99. *The Preventorium Child*—Harold G. Trimble, M.D., 508 Sixteenth Street, Oakland.

Our concept of childhood tuberculosis has changed materially since 1920. During this time many structures have been erected for the care of children who were presumably pretuberculous. There is but little need in many areas for these structures for the purpose for which they were originally intended. Such institutions can be used not only as educational centers, but also in specific cases in helping solve physical and psychological problems in individual children other than tuberculosis, as well as providing care for a limited time for a few selected cases of known T.B. contacts.

Discussion by Chesley Bush, M.D., Livermore; Clifford Sweet, M.D., Oakland; W. A. Hodges, M.D., Pasadena.

100. *Treatment of Meningococcic Meningitis*—Paul M. Hamilton, M.D., 248 East Main Street, Alhambra; William J. Mitchell, M.D. (by invitation), 1200 North State Street, Los Angeles, and Albert G. Bower, M.D., 136 No. Central Avenue, Glendale.

A review of 120 cases treated at the Los Angeles County General Hospital during the past two years, with results of treatment with serum, antitoxin, sulfanilamid, and combinations of these agents.

Discussion by Philip E. Rothman, M.D., Los Angeles; Edward B. Shaw, M.D., San Francisco.

101. *Intestinal Obstruction in Children*—W. J. Norris, M.D., 1136 West Sixth Street, Los Angeles.

This paper is based upon the findings in one hundred cases of different types of intestinal obstruction in children who were admitted to the Children's Hospital of Los Angeles. A résumé of the various types will be given with pictures and remarks.

Discussion by Henry Hunt Searls, M.D., San Francisco.

102. *Pyuria in the New-Born*—William M. Happ, M.D., 3875 Wilshire Boulevard, Los Angeles.

Pyuria or so-called pyelitis occurs in new-born babies, but the condition is seldom recognized because urine examinations are not done. The symptoms are fever and digestive upsets. It occurs in boys as often as in girls. The condition is frequently secondary to some congenital obstruction in the urinary tract. These obstructions are outlined in the paper. Illustrative cases presented.

Discussion by Elmer A. Belt, M.D., Los Angeles.

103. *Report of the Committee on Immunization Procedure*—Edward B. Shaw, M.D., 384 Post Street, San Francisco. (Committee report.)

The Committee on Immunization Procedures will submit a brief report detailing its recommendations regarding the use of the various procedures, some of which it is felt should be done routinely, some for special considerations and some not at all. There will be included a brief discussion of recommended methods for the performance of these procedures.

Committee members: Edward B. Shaw, M.D., Chairman, San Francisco; Paul M. Hamilton, M.D., Alhambra; Henry E. Stafford, M.D., Oakland.

Business Recess

Business meeting and election of officers.

Second Meeting—Ballroom

Wednesday, May 11, 8:30 a. m.

SYMPOSIUM ON VITAMINS

Joint meeting with Section on Medicine.

104. *Present Knowledge of Vitamins*—Nina Simmonds, Sc.D., University of California, San Francisco. (By invitation.)

During the past thirty years research in nutrition has yielded a large amount of detailed information regarding the essentials of an adequate diet. An understanding of the dietary properties of foods and the demonstration of the existence of the vitamins were made possible only by animal experimentation. The practical application of this research data to the physician will be the theme of the paper.

Discussion by William Palmer Lucas, M.D., San Francisco.

* Monitors: Ralph Netzley, M.D., Pasadena, and William Riley, M.D., San Francisco.

105. *Studies of the Blood Plasma—Vitamin C in Childhood*—James F. Rinehart, M.D., University of California Medical School, San Francisco.

This report is based upon the analysis of a large series of blood vitamin C determinations in childhood, both in health and disease. The reliability, usefulness and limitations of the method are considered, as is evidence pertaining to the possible influence of C deficiency in certain diseases.

Discussion by Roland P. Seitz, M.D., San Francisco.

106. *Studies on Hypoglycemia in Infants and Children*—Alexis F. Hartmann, M.D., Professor of Pediatrics, Washington University School of Medicine, St. Louis, Missouri. (By invitation.)

An outline will be presented of the various ways in which the hypoglycemia state may be produced, and observations on normal newly born infants, those born of diabetic mothers, and those with intracranial or adrenal hemorrhage, together with observations on the group of children with severe recurrent attacks of hypoglycemia, will be stressed.

107. *Diagnosis and Treatment of Vitamin Deficieney States*—Dwight L. Wilbur, M.D., 490 Post Street, San Francisco. (By invitation.)

In this presentation is discussed the diagnosis of vitamin deficiency states. These conditions most commonly consist of mild pathological and psysiological changes, and the diagnosis depends on the recognition of the clinical features of these deficiencies and on the interpretation of certain so-called diagnostic tests available for vitamins A, C, and D.

Discussion by Stacy R. Mettier, M.D., San Francisco; William C. Boeck, M.D., Los Angeles.

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Third Meeting—Ballroom

Wednesday, May 11, 1:30 p. m.

SYMPOSIUM ON SHOCK

This will be a joint meeting of the following sections: Medicine; Surgery, Obstetrics and Gynecology; Eye, Ear, Nose and Throat; Pathology; Pediatrics.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 12.)

XI

RADIOLOGY SECTION*

JOHN D. LAWSON, M.D., *Chairman*
California State Life Building
Sacramento

KARL M. BONOFF, M.D., *Secretary*
1930 Wilshire Boulevard
Los Angeles

First Meeting—Cottage "C"

Tuesday, May 10, 8:30 a. m.

Joint meeting with Section of Industrial Medicine and Surgery.

108. *Normal Angles in the Bones About Various Joints and Reporting in Degrees the Deviations from the Normal*—R. G. Van Nuys, M.D., 2490 Channing Way, Berkeley.

A presentation of normal bone angles about certain joints. An effort has been made to find a standard for measuring deviations from normal, and reporting the same in degrees and centimeters. Special attention is given to the central axis of weight bearing and its relation to the astragalus. The salient angles of the os calsis are of great importance. Wrist, elbow and hip angles are dealt with. Knee joint spaces have been measured and recorded. The paper will be given by aid of slides.

Discussion by Harold E. Crowe, M.D., Los Angeles.

109. *X-ray Evidenee of Healing of Fraetures of the Femoral Neek*—H. A. Hill, M.D., and L. H. Garland, M.D., 450 Sutter Street, San Francisco.

The question has been frequently asked: "What percentage of fractures of the neck of the femur in elderly persons unite by bone?" The answer, up to recent years, was usually "very few." However, since the introduction of various mechanical immobilizing devices, an increasing percentage of fractured femoral necks appear to show bony union. In order to determine the percentage of cases showing x-ray evidence of bony union at varying intervals following fractures, the present study was undertaken. A comparison of the clinical and roentgenological evaluations of union will be outlined, and the roentgenological results to date in the series of cases studied will be presented.

Discussion by K. S. Davis, M.D., Los Angeles.

110. *The Measurement of the Deformity of Alignment in Fraetures*—Clayton R. Johnson, M.D., Murphy Memorial Hospital, Whittier.

A method for exact measurement of the deformity of alignment is proposed, especially for those deformities which may affect the function of adjacent joints. The normal angulation of various joint surfaces is given along with the characteristic deformities which often occur with fracture.

Discussion by J. S. Woolford, M.D., Eureka.

111. *End Result Study on Fraetured Hips Treated at the San Franeiseo City and County Hospital*—Wilbur J. Cox, M.D., 450 Sutter Street, San Francisco.

This is a study of fifty fractures of the neck of the femur in which the Smith-Peterson nail was used as a method of internal fixation.

Discussion by John Wilson, M.D., Los Angeles; G. J. McChesney, M.D., San Francisco.

112. *Experienees with the Smith-Peterson Nail*—William Arthur Clark, M.D., 65 North Madison Avenue, Pasadena.

The author has used the Smith-Peterson pin since 1930, by the open reduction method exclusively. Accurate reduction is essential before fixation. Failures have been due to atrophy of the head and to having the pin too high in the spongy trochanter. A short history of metal fixation for fractures of the hip will be given.

Discussion by E. W. Cleary, San Francisco; Frazer Macpherson,M.D., San Diego.

Business Recess

Medieal Eeonomies meeting.

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Second Meeting—Cottage "D"

Wednesday, May 11, 8:30 a. m.

113. *Chairman's Address*—John D. Lawson, M.D., California State Life Building, Sacramento.

114. *The Roentgenologie Demonstration of Gall Bladder Tumors*—J. D. Coate, Peralta Hospital, Oakland.

Six cases will be included in this report, with complete pathologic studies on three proven cases. This series included both the papillomata and the adenomata.

Discussion by Sumner Everingham, M.D., Oakland; Paul Michael, M.D., Oakland.

* Monitors: E. W. Liljedahl, M.D., Los Angeles, and J. F. Chapman, M.D., Pasadena.

115. *The Roentgen Diagnosis of Diseases of the Ileocecal Region of the Gastro-intestinal Tract*—Joseph Jellen, M.D., Department of Radiology, Queen of Angels Hospital, Los Angeles.

There are a large number of diseases which show a special predilection for involvement of the ileocecal region of the gastro-intestinal tract. A classification of these diseases is presented, with a discussion of the roentgen diagnosis. A series of lantern slides will be shown illustrating the roentgen appearance of various diseases mentioned.

Discussion by Irving S. Ingber, M.D., San Francisco; C. M. Richards, M.D., San Jose.

116. *Marked Subperiosteal Calcification in Early Scurvy*—Carl D. Benninghoven, M.D., Mills Memorial Hospital, San Mateo.

Three cases which show the course from early onset to complete healing.

Discussion by James F. Rinehart, M.D., San Francisco; Carl Bowen, M.D., Oakland.

117. *Pulmonary Miliary Lesions*—Ray Carter, M.D., 1200 North State Street, Los Angeles.

Diseases producing them, factors influencing their visability on the film and the roentgen differentiation diagnosis.

Discussion by M. J. Geyman, M.D., Santa Barbara; M. L. Pindell, M.D., Los Angeles.

Business Recess

Business meeting and election of officers.

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Third Meeting—Cottage "D"

Wednesday, May 11, 1:30 p. m.

118. *Operation of a Multiple Portal Supervoltage X-ray Tube*—A. H. Warner, Ph.D., 1407 South Hope Street, Los Angeles. (By invitation.)

The mechanical and electrical features of a 600,000-volt installation are described. The radiation has been studied and depth dose curves and absorption curves in lead and aluminum are given.

Discussion by Robert S. Stone, M.D., San Francisco.

119. *What Can One Expect from Radiation Therapy in Cancer of the Rectum and Anus*—Orville N. Meland, M.D., 1407 South Hope Street, Los Angeles.

Carcinoma of the rectum offers great obstacles to its successful treatment by radiation alone. This is due to its situation and its radioresistance, so that the results are largely palliative. Carcinoma of the anus, on the other hand, is accessible, and is often successfully treated by radiation alone.

Discussion by G. S. Sharp, M.D., Pasadena; Clyde Emery, M.D., Los Angeles.

120. *X-ray in Treatment of Carcinoma of the Breast*—Lyell C. Kinney, M.D., 1831 Fourth Street, San Diego.

Except in the early localized cases, the newer methods of fractional radiation combined with surgery will practically double the present curability. Newer radiation methods make it possible to restrict the field of operability, as radical surgery offers little paliation in advanced cases. Radiation with or without simple mastectomy offers real paliation and will prolong life. The paper will discuss indications for x-ray treatment and the present conception of what is adequate radiation in carcinoma of the breast.

Discussion by Alson R. Kilgore, M.D., San Francisco.

121. *Use of Radiation Therapy in Acute and Chronic Inflammatory Conditions*—Henry Johnson Ullmann, M.D., 1520 Chapala Street, Santa Barbara.

The discussion includes all inflammatory processes other than dermatoses, malignant and premalignant lesions.

Discussion by William H. Sargent, M.D., Oakland.

XII

UROLOGY SECTION*

Lloyd E. Kindall, M.D., *Chairman*
400 Twenty-ninth Street, Oakland

Carl F. Rusche, M.D., *Secretary*
1680 North Vine Street, Hollywood

First Meeting—Cottage "A"

Wednesday, May 11, 8:30 a. m.

122. *Congenital Solitary Kidney*—Report of Two Cases—Frederick A. Bennetts, M.D., 1921 Wilshire Boulevard, Los Angeles.

One, occurring in an infant seven months of age with hydroureter and hydronephrosis. Another, in a girl seventeen years of age, complicated by hydronephrosis secondary to congenital adhesions and anomalous blood vessels about upper ureter and lower pole of kidney, producing acute Dietl's crisis and anuria.

Discussion by Carl Rusche, M.D., Hollywood; Edward Beach, M.D., Sacramento.

123. *The Cure of Gonorrhea: An Immunologic Problem*—Edward W. Beach, M.D., Medical Dental Building, Sacramento.

Gonorrhea is concededly a self-limiting disease. Stated differently, the cure of gonorrhea is contingent to and predicated upon the development of complete tissue immunity. A much better understanding of this immunologic mechanism must be contrived before the advent of more efficient treatment and more intelligent application. To this end, modern concepts anent this autogenetic phenomena are briefly reviewed herein. An attempt is likewise made to evaluate the newer forms of therapy (particularly chemotherapy and induced fever) in terms of immunologic accomplishments as applied to the problem of cure.

Discussion by Arno Folte, M.D., San Francisco; J. J. Crane, M.D., Los Angeles.

124. *The diagnosis and Treatment of Secondary Anaërobic Infections of Kidney Wounds*—Charles P. Mathé, M.D., 450 Sutter Street, San Francisco.

Report of case presenting secondary anaërobic streptococcic infection of kidney wound following nephropexy and sympathectomy. Elongated nonpus-producing blind sinuses were encountered between abdominal muscular layers. Anaërobic infection diagnosed. Cleared up by local administration, intra and hyperdermic injection of antigen and intramuscular injections of immunized blood. Problem of diagnosis. Treatment. Prognosis and results.

Discussion by Thomas Gibson, M.D., San Francisco; Clark Johnson, M.D., San Francisco.

125. *Suprapubic Bladder Drainage*—Henry A. R. Kreutzmann, M.D., 2000 Van Ness Avenue, San Francisco.

This paper explains in detail the method of inserting the improved suprapubic trocar just above the symphysis pubis into the distended bladder. Its use in cases of acute retention resulting from hyperthrophied prostate or impassable urethral stricture is discussed. The advantages of this method over indwelling catheter for drainage preliminary to prostatectomy and the results obtained by this method in seventy cases are discussed in detail. A motion picture illustrates the operation.

Discussion by Paul A. Ferrier, M.D., Pasadena; Albert M. Meads, M.D., Oakland.

126. *Carcinoma of the Prostate*—Frank Hinman, M.D., 603 Fitzhugh Building, San Francisco.

Introduction: Incidence, diagnosis, treatment. Analysis of 191 cases with type of treatment and results. The result in detail of forty-five cases treated by radical operation.

Discussion by Arthur B. Cecil, M.D., Los Angeles; A. Elmer Belt, M.D., Los Angeles.

* Monitors: Donald Charnock, M. D., Los Angeles, and Chester H. Mackay, M. D., Los Angeles.

126a. *Experimental Production in Animals of Conditions Similar to Those of the Adrenal Syndrome in Humans*—James B. Hamilton, Ph. D., Yale University School of Medicine, New Haven, Connecticut. (By invitation.)

It has been reported that the presence in the female of adequate amounts of male hormone substance will cause masculinization changes in the clitoris and the homologue of the male prostatic glands and cessation of the female reproductive cycle. If given sufficiently early in the prenatal period, embryological defects result. These and other changes following androgen treatment constitute a condition which corresponds even in some fine details to that which occurs in the adrenal syndrome of humans with tumor or hyperplasia of the adrenal.

127. *Chairman's Address: Conservative Renal Surgery—With Particular Reference to Kidney Trauma*—Lloyd Kindall, M.D., 400 Twenty-ninth Street, Oakland.

❦

Second Meeting—Cottage "A"

Wednesday, May 11, 1:30 p.m.

128. *Treatment of Vesical Diverticula*—Roger W. Barnes, M.D., and R. Theodore Bergman, M.D., Suite 707, Medico-Dental Building, Los Angeles.

A comprehensive review of the literature is made pertaining to the etiology, pathology, and treatment of vesical diverticula. A conservative method, transurethral diverticulotomy, is also discussed.

Discussion by J. J. Crane, M.D., Los Angeles; A. A. Kutzmann, M.D., Los Angeles.

129. *Diagnosis and Treatment of Urinary Tract Infections*—James R. Dillon, M.D., 490 Post Street, San Francisco.

Two years ago a report was made on urinary tract infections with clear urine. Further studies and observations on diagnostic technique and treatment will be presented under the above title, illustrated by lantern slides.

Discussion by A. J. Scholl, M.D., Los Angeles; A. M. Meads, M.D., Oakland; Nathan Hale, M.D., Sacramento.

130. *Limitation of Male Sex Hormone Therapy for Benign Hyperthrophy*—Robert V. Day, M.D., 1911 Wilshire Boulevard, and Harry W. Martin, M.D., 6253 Hollywood Boulevard, Los Angeles.

Testosterone itself, and both liposoluble and hydrosoluble testis extracts, are potent in relieving hesitancy, feeble stream and nycturia in Grade 1 and Grade 2 hyperthrophied prostates, and often the residual markedly decreases. It cannot be demonstrated that the prostate is actually decreased in its dimensions. This form of therapy is valuable in certain types of cases where surgery carries too great an element of danger or it seems necessary to the patient himself to postpone a surgical procedure for economic or other reasons personal to him. Like insulin, the treatment should not be discontinued, but the dose may be diminished in many cases. This form of therapy is not in any sense a substitute for surgical relief of major prostatic obstruction.

Discussion by Miley B. Wesson, M.D., San Francisco; Paul A. Ferrier, M.D., Pasadena.

131. *The Cystoscopic Implantation of Radium Element in Tumors of the Bladder—A New Technique*—Thomas D. Moore, M.D., 899 Madison Avenue, Memphis, Tennessee. (By invitation.)

132 *Causes of Persistent Sinus Following Suprapubic Cystotomy with Reports of Unusual Cases*—Ben D. Massey, M.D., 112 North Madison Avenue, Pasadena.

Persistence or reformation of a suprapubic sinus is usually due to obstruction of the bladder neck. The paper discusses a patient with myeloid leukemia who developed a suprapubic abscess and urinary sinus five years after prostatectomy. This sinus failed to heal in the absence of lower urinary tract obstruction. Necropsy findings are reported and the rôle of infection is discussed as a causal factor in these conditions.

Discussion by Robert V. Day, M.D., Los Angeles; H. C. Bumpus, M.D., Pasadena.

133. *Congenital Renal Anomalies, with Special Reference to Horseshoe Kidney, with Motion Picture*—Carl Rusche, M.D., and Samuel K. Bacon, M.D., 1680 North Vine Street, Hollywood.

The congenital renal anomaly—horseshoe kidney (with motion pictures in color showing the operative technique for calculous disease). This paper briefly reviews renal embryology, the anatomical features, frequency, and clinical aspects of horseshoe kidney. The management of a patient with horseshoe kidney and calculous disease is reported and the operative technique is demonstrated by motion picture in color.

Discussion by William E. Stevens, M.D., San Francisco; B. H. Hager, M.D., Los Angeles.

134. *Believe It or Not*—Wirt B. Dakin, M.D., 802 Pacific Mutual Building, Los Angeles, California.

A collection of reports of such a startling and incredible nature as to immediately attract keen interest and curiosity. Cases with strangely baffling symptoms, startling pathological conditions and such weird operative findings that one would scarcely give them credence unless he saw them with his own eyes. They represent contributions from many of our leading urologists that are a refreshing stimulus to what is bound to become at times a jaded medical appetite. Many amusing incidents are included.

Business Recess

Business meeting and election of officers.



Fig. 1.—Front view of the Huntington Hotel showing a portion of the Horseshoe Gardens.

III—HOUSE OF DELEGATES MEETINGS

35th ANNUAL SESSION—MAIN BALLROOM, HOTEL HUNTINGTON

Speaker, LOWELL S. GOIN, Los Angeles *Vice-Speaker,* JOHN H. GRAVES, San Francisco
Secretary, F. C. WARNSHUIS, San Francisco

FIRST MEETING

Monday, May 9, 8 p. m.

Order of Business

1. Call to order.
2. Report of Committee on Credentials.
3. Roll call.
4. Announcement and approval of Reference Committees:
 (*a*) Reports of Officers, Standing and Special Committees.
 (*b*) Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.
 (*c*) Credentials.
 (*d*) Report of Council and Secretary-Treasurer.
5. President's address—Howard Morrow.
 Reports:*
6. Annual report of the Council—Morton R. Gibbons, Chairman.
7. Report of the Trustees of the California Medical Association—Morton R. Gibbons, President.
8. Report of Auditing Committee — Karl L. Schaupp, Chairman.
9. Report of Secretary-Treasurer—Frederick C. Warnshuis.
10. Report of Editor—George H. Kress.
11. Report of General Counsel—Hartley F. Peart. Mr. Peart will discuss malpractice insurance problems.
12. Report of Committee on Public Relations—Charles A. Dukes, Chairman.
13. Report of Standing and Special Committees:
 A. Standing Committees:
 Executive Committee—Karl L. Schaupp.
 Committee on Associated Societies and Technical Groups—John V. Barrow.
 Committee on Health and Public Instruction—Fred B. Clarke.
 Committee on History and Obituaries—Frank R. Makinson.
 Committee on Hospitals, Dispensaries and Clinics—Daniel Crosby.
 Committee on Industrial Practice—Morton R. Gibbons.
 Committee on Medical Defense—George G. Reinle.
 Committee on Medical Economics—John H. Graves.
 Committee on Medical Education and Medical Institutions—Loren R. Chandler.
 Committee on Membership and Organization—E. Vincent Askey.
 Committee on Postgraduate Activities—John C. Ruddock.
 Committee on Publications—Ralph Eusden.
 Committee on Public Policy and Legislation—Junius B. Harris.
 Committee on Scientific Work—Frederick C. Warnshuis.
 Committee on Public Relations—Charles A. Dukes.
 Cancer Commission—Charles A. Dukes.
 B. Special Committees:
 Committee on Animal Experimentation—Philip K. Gilman.
 Committee on Syphilis—Howard Morrow.
 Committee on a Basic Science Law—George H. Kress.
 Committee on California Medical Economic Survey—Edward M. Pallette.
14. Unfinished Business.
 A. Amendments to Constitution:
 Amendment to Constitution, Article VII, Section 1.
 (d) *Resolution Regarding Nomination and Election of District Councilors*
 Resolved, That Section 1 of Article VII of the Constitution of this Association be and hereby is amended as follows, by striking out all of the third paragraph of said Section 1 of Article VII, reading as follows:
 "The nine district councilors shall be elected as follows: Prior to the time set for the election of district councilors the delegates of each councilor district for which a councilorship is about to become vacant, shall meet, organize, and in due form elect one or more members of the said councilor district as the nominee or nominees for the said vacancy. Such nomination or nominations shall be submitted in writing, signed by at least two delegates who were present at such meeting, and shall be given to the Secretary-Treasurer, by him to be transmitted to the House of Delegates. The House of Delegates may make additional nominations from the floor of the House, and in the event that the delegates from a councilor district fail to submit a nomination or nominations, shall on its own account proceed to make nominations for each district councilor vacancy. A vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship"; and by inserting in lieu thereof the following:
 The nine district councilors shall be elected as follows: At least one month prior to the time set for the election of district councilors, the Secretary-Treasurer shall mail a written notice to each delegate, addressed to his address listed in the Association's records, of each councilor district for which a councilorship is about to become vacant, notifying the delegates of the time, which must be at least two weeks after the mailing of the notices, and a place designated by the Secretary-Treasurer, for the nomination meeting of the delegates of said councilor district.
 At the time and place designated in said written notice, delegates shall meet, organize and elect by a majority vote a member of the said councilor district as nominee for district councilor for such councilor district for the ensuing term. The delegates shall then transmit in writing to the Secretary-Treasurer the result of such nomination meeting, and the Secretary-Treasurer shall report the same to the House of Delegates. The nominee, regularly nominated by the delegates present at the nomination meeting pursuant to this section, shall be deemed elected by the House of Delegates at the time of the report of the Secretary-Treasurer. In the event that the delegates from a councilor district fail to submit a nomination, the House of Delegates shall, on its own account, proceed to make nominations from the floor of the House, and in such event a vote shall be taken by the House of Delegates to determine which nominee shall be elected to the vacant councilorship
15. Resolutions and New Business.
 (NOTE: *All resolutions must be presented in writing and in triplicate.*)
16. Approval of Minutes.
17. Recess to Wednesday, 8:00 p. m.

SECOND MEETING

Wednesday, May 11, 8:00 p. m.

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1939 Annual Session.
5. Elections:
 (*a*) President-Elect.
 (*b*) Speaker.
 (*c*) Vice-Speaker.
 (*d*) Councilors:
 First District—Calvert L. Emmons, Ontario (term expiring).
 Fourth District—Axcel E. Anderson, Fresno (term expiring).
 Seventh District—O. D. Hamlin, Oakland (term expiring).
 (*e*) Councilors-at-Large:
 Harry H. Wilson, Los Angeles (term expiring).
 Morton R. Gibbons, San Francisco (term expiring).
 (*f*) Delegates to the American Medical Association—Incumbents:
 Charles A. Dukes, Oakland (term expiring).
 Edward M. Pallette, Los Angeles (term expiring).
 Robert A. Peers, Colfax (term expiring).
 William R. Molony, Sr., Los Angeles (term expiring).
 (*g*) Alternate Delegates to the American Medical Association—Incumbents:
 Edward N. Ewer, Oakland (term expiring).
 William H. Kiger, Los Angeles (term expiring).
 F. F. Gundrum, Sacramento (term expiring).
 John C. Ruddock, Los Angeles (term expiring).
6. Announcement and Approval of Members of Standing Committees Elected by the Council.
7. Report of Reference Committees:
 (*a*) Report of Council and Secretary-Treasurer.
 (*b*) Reports of Officers, Standing and Special Committees.
 (*c*) Resolutions, Amendments, New and Miscellaneous Business.
8. Unfinished Business.
9. Presentation of Officers:
 President.
 President-Elect.
 Speaker.
 Vice-Speaker.
10. Presentation of President's Certificate to Howard Morrow.
11. Approval of Minutes.
12. Adjournment.

* Reports of Officers, Standing and Special Committees appear in full text in the Pre-Convention Bulletin, printed as an Appendix to this Annual Session program. (See page 33.

IV—OTHER MEETINGS

CANCER COMMISSION PATHOLOGY CONFERENCE

Sunday, May 8, 9 a. m. to 4:30 p. m.

359 Science Building, University of Southern California Medical School, Thirty-sixth Place and University Avenue, Los Angeles

The annual Conference on Pathology, sponsored by the California Medical Association, will take place in Room 359 of the Science Building, 3661 University Avenue, corner of Thirty-sixth Place and University Avenue, Los Angeles.

The meeting is being held in this location rather than at the Hotel Huntington because of better lighting facilities, etc. The program will include morning and afternoon sessions. Interesting cases are to be presented for diagnosis, and it is hoped that reports will be made on cases previously presented.

All those who desire to present cases and slides are requested to notify the chairman of the committee, Alvin G. Foord, M. D., 749 Fairmont Avenue, Pasadena, at once. One hundred prepared slides and a copy of the case history, which has to be mimeographed, are likewise to be sent.

If you wish to attend, register with the chairman of the committee or the secretary of the Cancer Commission, 450 Sutter Building, San Francisco, as soon as possible.

Bring your own microscopes. Attendance will be limited.

CANCER COMMISSION RADIOLOGY CONFERENCE

Sunday, May 8, 9:30 a. m. to 4 p. m.

Hotel Huntington, Pasadena

The Radiological Conference, sponsored by the Cancer Commission of the California Medical Association, will be held at the Hotel Huntington, Main Ballroom, on Sunday, May 8, from 9:30 a. m. to 4 p. m.

The discussion will center about radiotherapy, as well as diagnosis.

Those who wish to attend should register with the chairman of the committee, William E. Costolow, M. D., 1407 South Hope Street, Los Angeles, or with the secretary of the Cancer Commission, 450 Sutter Street, San Francisco. Likewise, those who wish to present material for diagnosis or discussion of therapy should contact Doctor Meland as soon as possible.

It is necessary that everyone who wishes to participate should register as attendance will be limited to insure the greatest benefit to those interested.

MEDICAL SOCIETY OF THE STATE OF CALIFORNIA

Wednesday, May 11, 4 p. m., Crystal Room

There will be a meeting of the members of this legal protection organization. Chairman O. D. Hamlin will preside. Reports will be rendered. Officers will be elected. Plans for expansion will be presented. Every member of the California Medical Association is invited, in fact, urged to attend this annual meeting.

V—SCIENTIFIC EXHIBITS

Patio, Hotel Huntington

1. *Heart Association*—Howard F. West, M. D., 1930 Wilshire Boulevard, Los Angeles.
 Exhibits and daily demonstrations and moving pictures mornings and afternoons. Watch bulletin board for schedule.
2. *Models of the Prostate as Ascertained by Rectal Palpation*—Roger W. Barnes, M. D., Medico-Dental Building, Los Angeles.
 Models of the prostate as ascertained by rectal palpation, demonstrating the normal and eleven different pathological conditions in the prostate. This is to be accompanied by roentgenograms, pathological specimens, and slides of these pathological conditions of the prostate and associated conditions.
3. *Convalescent Serum*—C. M. Hyland, M.D., Children's Hospital Society, 4614 Sunset Boulevard, Los Angeles.
 The exhibit of the Children's Hospital convalescent serum includes a demonstration of serum dehydration by the lyophile machine, a motion picture showing the different steps in the pooling and bottling of convalescent serum, various packages of dried and liquid serum as furnished for prophylaxis and treatment, and case charts which show the result of serum therapy.
4. *Tuberculous Tracheobronchitis*—W. R. Oechsli, M.D., Department of Charities, Los Angeles.
 An exhibit comprised of the clinical, bronchoscopic, x-ray, and pathological findings in tracheobronchitis occurring as a disease entity as well as a complication of pulmonary tuberculosis, based on over one hundred proved cases. The findings are correlated and presented in the form of charts, x-ray films, diagnosis, and pathological specimens.
5. *Muscle-Splitting Extraperitoneal Lumbar Ganglionectomy*—Felix L. Pearl, M. D., 450 Sutter Street, San Francisco.
 This exhibit consists of a colored motion picture depicting the technique of muscle-splitting extraperitoneal lumbar ganglionectomy as developed by the author. The picture shows the steps of the operation, removal of the sympathetic chain, closure, and the advantages of the method. Ureter, vena cava, aorta, and other retroperitoneal structures are well shown.
6. *Plastic Surgery*—Fred Lindenberg, M. D., 1680 North Vine Street, Hollywood.
 Results of reconstructive and cosmetic cases of plastic surgery. Demonstration with life-size masks and unretouched photographs.
7. *Reconstructive Plastic and Oral Surgery*—Arthur E. Smith, M.D., D.D.S., and James B. Johnson, M.D., 1930 Wilshire Boulevard, Los Angeles.
 This exhibit consists of numerous life-sized contact models reproduced in natural colors and arranged in series to demonstrate various congenital and acquired deformities and their correction by reconstructive plastic and oral surgery. These include cases of mutilation from automobile accidents, congenital cleft palate and lip, malignancies of the face and oral cavity and many other classical conditions encountered by the surgeon limiting himself to this field.
8. *Diseases of the Thyroid Gland*—Harold L. Thompson, M.D., 1930 Wilshire Boulevard, Los Angeles.
 The exhibit will consist of charts, outlines, drawings, and pathological specimens covering diseases of the thyroid gland in a general way.
9. *Manipulative Surgery*—G. Mosser Taylor, M.D., 2007 Wilshire Boulevard, Los Angeles.
 Charts showing indications, contraindications, and complications, illustrated by some forty artistic drawings, mounted and well labeled, and grouped under the different joints, such as the neck, low back, so-called "sacro-iliac" lesions, shoulders, elbows, knees, and feet. Besides this, a colored motion picture completes the exhibit. This work has been developed from ten years of clinical practice, and is in keeping with the latest thought, particularly on the subject of low-back pain.

VI—ENTERTAINMENT

Calendar

Sunday Afternoon:

Tea served, Hotel Huntington.

Sunday Night:

First run of moving pictures, Hotel Huntington.

Monday Afternoon:

Trip to moving-picture studio, arranged particularly for Auxiliary, but open to men.

Monday Night:

Musicale, Hotel Huntington.

Tuesday, 7:30 a. m.

Past Presidents' breakfast. Past presidents of the Association will hold their annual breakfast. See bulletin board or inquire at registration desk for name of the private dining room assigned for this function.

Tuesday Afternoon:

Trip to Griffith Park Planetarium, arranged particularly for the Auxiliary, but open to men.

Tuesday Night:

President's dinner and entertainment, Hotel Huntington. Reservations must be made with the Hotel Huntington management by noon on Tuesday. (Price, $2.50 per plate.) Guests of Hotel Huntington obtain special tickets from room clerk.

Golf Clubs

	Fees
Midwick Country Club	$2.00
San Gabriel Country Club	1.00
Flintridge Country Club	1.50
Altadena Golf Club	1.00
Brookside Golf Course	1.00
Annandale Country Club	2.00

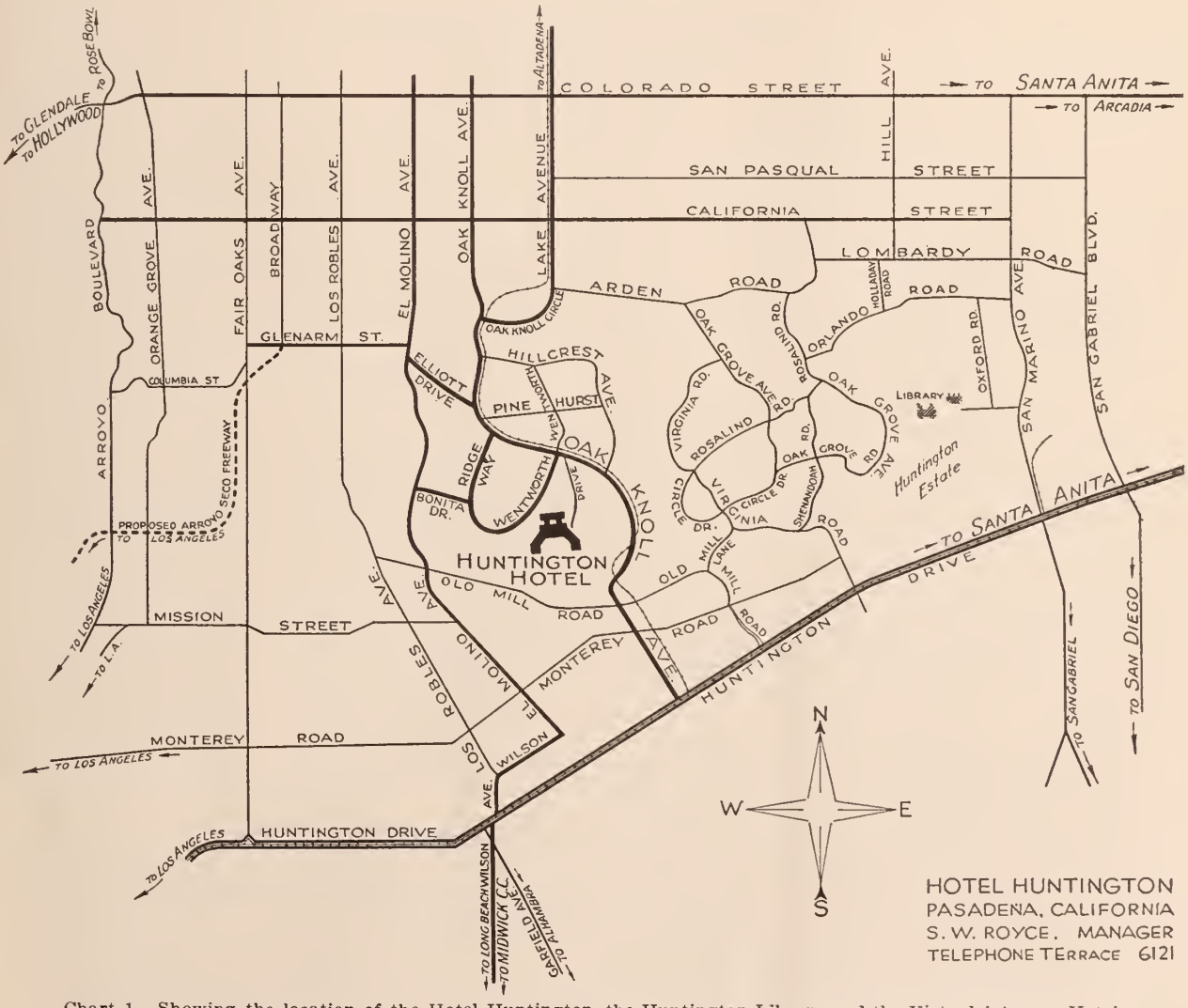
Other Entertainment

Demonstrations of giant x-ray and other electrical equipment has been promised at the California Institute of Technology. Registration at the desk will be necessary in order to provide for accommodations. Definite dates will be set later by the Institute.

Demonstration of astronomical equipment at Mount Wilson Observatory will be possible during afternoons, if sufficient register at the desk. Night observations *may* be possible, but could not be promised this far in advance by the officials at Mount Wilson.

The Arrangements Committee will be glad to arrange any unofficial trips for individuals or parties who will apply in advance, such as charter boats for deep sea fishing, plane trip to Boulder Dam, or reservations at Catalina Island.

Tickets for admission to the Huuntington Library must be applied for well in advance, either through the committee or direct to the Huntington Library. The Gay Lion Farm, the Pasadena Community Playhouse, and Olivera Street in Los Angeles, are other suggested points of interest, as also the Padua Hills Theater and dining room above Claremont.



HOTEL HUNTINGTON
PASADENA, CALIFORNIA
S. W. ROYCE, MANAGER
TELEPHONE TERRACE 6121

Chart 1.—Showing the location of the Hotel Huntington, the Huntington Library and the Vista del Arroyo Hotel. (Vista del Arroyo Hotel is located at the extreme upper left corner at Arroyo Boulevard and Colorado Street.)



MRS. HOBART ROGERS
President, Woman's Auxiliary to the California Medical Association
1937-1938



MRS. HARRY E. HENDERSON
Recording Secretary, Woman's Auxiliary to the California Medical Association
1937-1938

VII—WOMAN'S AUXILIARY

Ninth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Hotel Huntington, Pasadena

MRS. HOBART ROGERS, *President*
(1137 Mandana Boulevard, Oakland)

MRS. ARTHUR T. NEWCOMB, *Convention Chairman*
(1 Richmond Place, Pasadena)

Sunday, May 8

Arrival of delegates, members, and guests, greeted by a delegation of hostesses.

3:00-7:00 p. m.—Registration.

4:00 p. m.—Tea and music, Hotel Huntington lobby.

6:00 p. m.—Informal round-table dinner for Auxiliary members.

8:30 p. m.—Moving pictures, Hotel Huntington Ballroom.

Monday, May 9

9:00 a. m. to 7:00 p. m.—Registration.

9:00 a. m.—Pre-Convention State Board meeting, Crystal Room, Hotel Huntington.

10:00 a. m.—Opening session of the California Medical Association. All Auxiliary members are urged to attend.

12:30 p.m.—Informal round-table luncheon.

1:30 p. m.—Trip to Moving Picture Studio. (Subject to change.) (Price, $3; this includes bus fare and entrance to the studio.)

9:00 p. m.—Musicale in honor of Mrs. Howard Morrow, wife of the president of the California Medical Association, with members of the State Board receiving.

10:15 p. m.—Reception. Light refreshments.

Tuesday, May 10

9:00 a. m. to 7:00 p. m.—Registration.

9:30 a. m.—First general meeting of the ninth annual convention at *Hotel Vista del Arroyo,* Mrs. Hobart Rogers presiding.

12:15 p. m.—Luncheon, Hotel Vista del Arroyo, honoring Mrs. Hobart Rogers, with Mrs. James Fulton Percy presiding. Members of the State Advisory Board will be guests of honor. Dr. Lowell S. Goin of Los Angeles will be the guest speaker. Presentation of the Doane Membership Trophy by Mrs. William Henry Sargent of Oakland. (Price $1.25, plus tax.)

2:15 p. m.—Optional trips: (1) Visit to the Huntington Library art exhibits and gardens. (2) Planetarium demonstration and lecture at Griffith Park Observatory, stopping en route to view the noted art wonder, "The Lord's Supper," at Forest Lawn, and returning through the Flintridge Hills to Pasadena. (Price, $1.) Busses leave from both hotels (Huntington and Vista del Arroyo).

7:30 p. m.—President's dinner and dance of the California Medical Association at the Hotel Huntington.

Wednesday, May 11

9:00-11:00 a. m.—Registration.

9:30 a. m.—Second general meeting of the ninth annual convention, Hotel Vista del Arroyo, Mrs. Hobart Rogers presiding.

12:15 p. m.—Luncheon, honoring the incoming president, Mrs. Clifford Andrews Wright, and members of the State Board, with Mrs. Hobart Rogers presiding. The past state presidents will be guests of honor. The program and the speaker will be announced later. (Price $1.25, plus tax.)

2:30 p. m.—Post-Convention State Board meeting, Mrs. Clifford Andrews Wright presiding.

Free afternoon.

Courtesy cards to golf and beach clubs are available to members.

8:30 p. m.—Evening attractions: Pasadena Community Playhouse; moving pictures. Detailed bulletin in the hotel lobby.

(For further information, consult attendants at Woman's Auxiliary information desk.)

President's Report

To the Members of the Auxiliary:

The Woman's Auxiliary to the California Medical Association is making progress. Early in the year a four-point program was outlined, and the county units have worked toward the fulfillment of these aims. The points stressed were:

1. *Organization.*—California has nineteen organized county units out of a possible thirty-nine. We have lost

one county and gained three—Santa Cruz, Butte, and Tulare. The organization of these three counties has added approximately sixty members to the State Auxiliary. Appreciable gains in membership have been recorded in most of the counties. With two more months in our year, we are still striving toward our goal—an Auxiliary in every county where a medical society exists.

2. *Lending Library.*—Our library is being used by county groups in planning programs. Books and plays suitable for health education programs have been added. The Library Committee is conducting a contest in an attempt to secure a suitable book plate for the books in our library. Results of this contest are not yet reported. We are urging that the Auxiliaries use the material in the library in assisting lay organizations to plan health programs.

3. *Public Relations.*—We are happy to report that more and more of our doctors' wives are taking active part in lay organizations and lending their influence in seeing that persons presenting health programs before these groups are capable of doing so. Many of the counties have sponsored lectures on venereal diseases, tuberculosis, cancer control, and other topics of vital interest to the people. These lectures have been well attended by the lay public. Two counties have conducted Health Institutes, and the attendance at these functions has been most gratifying.

As our year closes and the summer approaches, we are not contemplating on a subsidence of interest in our work. We hope to have our members working on a program of districting the patients of doctors in order that voting power may be readily reached relative to the public interest. This task will be undertaken under direct supervision of the California Medical Association.

We have actively sponsored *Hygeia.* Our goal was that each member be responsible for one subscription to *Hygeia.* While so far this goal has not been reached, we have made decided gain in promoting *Hygeia* this year. Marin County reports, on the basis of one subscription per member, 300 per cent subscription. Every county has participated in this campaign to place the lay journal of the American Medical Association before the public.

4. *National Convention.*—We have endeavored to stimulate interest in the National Convention, which meets in San Francisco, June 13 to 17 of this year. This is the first time in the existence of the Woman's Auxiliary to the California Medical Association that we have been privileged to entertain the national organization. The local committee is working very hard to make this convention an outstanding one—one that is worthy of the organization and of California.

The Woman's Auxiliary is fast becoming a leavening influence in the state and nation. We are being called upon for assistance in health programs for lay groups. It is through this affiliation that we are able to promote the conservation of public health and the advancement of medical science. We are attempting to assume our responsibility for leadership in these matters.

The achievements of this year have been accomplished through the fullest coöperation of every department and the enthusiastic effort of the individual members. The progress we feel we have made has been due largely to the guidance and loyal support of our Advisory Board of the California Medical Association. For this help the members in general, and I especially, am indeed grateful.

MRS. HOBART ROGERS, *President.*

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

CONVENTION COMMITTEES

MRS. ARTHUR T. NEWCOMB, *General Chairman*

Credentials and Registrations

Mrs. Charles C. Hall, Chairman
Mrs. Mark Albert Glaser, Local Chairman

Mrs. John Severy Hibben
Mrs. Alvin G. Foord
Mrs. Arthur Bowen
Mrs. Edward W. Bak
Mrs. Hans Schiffbauer
Mrs. Jesse L. Brockow
Mrs. Edward M. Pallette
Mrs. Charles Coghlan
Mrs. Hyman Miller
Mrs. Rolland Thompson
Mrs. Paul A. Foster
Mrs. C. J. Stadfield
Mrs. Joseph B. Stevens
Mrs. Frederic N. Tyroler
Mrs. Edwin J. Kirkpatrick
Mrs. Herbert S. Mooney

Information

Mrs. William C. Boeck, Chairman
Mrs. Robert O'Neal, Vice-Chairman

Mrs. William A. Swim
Mrs. Paul A. Quaintance
Mrs. John Martin Askey
Mrs. Clifton H. Briggs
Mrs. Carl R. Howson
Mrs. Harold E. Crowe
Mrs. Franklin Farman
Mrs. Victor E. Thomas

Hospitality

Mrs. Eliot Alden, Mrs. James Fulton Percy, Co-chairmen

Mrs. Mark Albert Glaser
Mrs. C. G. Stadfield
Mrs. William H. Leake
Mrs. Francis C. Hertzog
Mrs. Edwin B. Plimpton
Mrs. Charles E. Futch
Mrs. Hiram C. Weaver
Mrs. E. Vincent Askey
Mrs. Grant Lanphere
Mrs. G. H. Homme
Mrs. John P. Nuttall
Mrs. Harry V. Brown
Mrs. G. H. Ernsberger
Mrs. Rafe C. Chaffin
Mrs. Charles E. Phillips
Mrs. K. P. Stadlinger
Mrs. Harold E. Peterson
Mrs. Simon Jesberg
Mrs. Clifford B. Walker
Mrs. Louis F. X. Wilheim
Mrs. Scott D. Gleeten
Mrs. R. C. Olmsted
Mrs. Clifford Andrews Wright
Mrs. Edward Winslow Jones
Mrs. John Martin Askey
Mrs. Newell Jones
Mrs. P. A. Gallant
Mrs. Robert L. Carroll
Mrs. Henry T. S. Bonesteel
Mrs. Robert E. O'Conner
Mrs. Walter H. Boyd
Mrs. A. Brockway
Mrs. Clinton D. Hubbard
Mrs. George H. Kress
Mrs. C. Max Anderson
Mrs. G. C. Sabichi
Mrs. Frank E. Detling
Mrs. E. Eric Larson
Mrs. Benjamin H. Sherman
Mrs. L. C. Burwell
Mrs. Benjamin M. Frees
Mrs. Crayton C. Snyder
Mrs. George Darby Maner
Mrs. H. L. Charles

Special Hostesses (Daughters of Auxiliary Members)

Miss Phyllis Doane
Miss Gertrude Bames
Miss Marjorie Sherman
Miss Dorothy Spiers
Miss Dona Gale Myers
Miss Maxine Quistgard
Miss Florence Alden
Mrs. Griffith Page
Mrs. Hugh Sutherland
Mrs. Dean Christy
Mrs. Wallace Burton
Miss Shirley Brockway
Miss Helma Bames
Miss Elizabeth Pallette
Miss Faith Scroggy
Miss Jane Gale Myers
Miss Joe Dee Thomas
Mrs. Donald Laing
Mrs. Ralph Starkweather
Mrs. Ward Rolland
Mrs. Carroll Graham

Transportation

Mrs. Rollan W. Kraft, Chairman

Mrs. Harry Wiley
Mrs. Ralph Eusden
Mrs. Roy R. Miller
Mrs. Otto Bames
Mrs. L. Grant Baldwin
Mrs. Joseph Zeiler
Mrs. Harry F. Markolf
Mrs. Paul Blaisdell
Mrs. Peter H. Blong

Ushers and Pages

Mrs. Ward M. Rolland, Mrs. Carl E. Ebert, Co-Chairmen

Mrs. Russell Decker
Mrs. George T. Burke
Mrs. Lyle G. Craig
Mrs. Jesse L. Brockow
Mrs. John B. Todd
Mrs. Ralph E. Netzley
Mrs. William M. Maloney, Jr.
Mrs. Charles Coghlan
Miss Phyllis S. Doane
Mrs. A. R. Graham

Decorations and Flowers

Mrs. Edward Winslow Jones, Chairman

Mrs. William H. Daniels
Mrs. Russell M. Decker
Mrs. Wesley J. Woolston
Mrs. Vincent F. Flynn
Mrs. Frederick R. Speik

Headquarters

Mrs. Arthur T. Newcomb
Mrs. James Fulton Percy
Mrs. Philip Schuyler Doane

Supplies and Printing

Mrs. Philip Schuyler Doane

Entertainment

Mrs. Elmer Belt, Chairman
Musicale—Monday Evening

Studio Auto Tour

Mrs. Mark Albert Glaser, Chairman

Mrs. Walter Boyd
Mrs. Harry B. Breitman
Mrs. Clifford B. Walker
Mrs. Harold D. Barnard
Mrs. David N. Yaker

Luncheons

Tuesday, Mrs. William H. Leake, Chairman
Wednesday, Mrs. A. Brockway, Chairman

Mrs. R. B. Hope
Mrs. Otto Bames
Mrs. E. C. Pallette

Finance

Mrs. H. Waldo Spiers, Chairman

Mrs. Hewell Jones
Mrs. R. C. Chaffin

Publicity

Mrs. Arthur J. Annis, Chairman

Mrs. Edward H. Williams
Mrs. Joseph Zeiler
Mrs. Walter H. Boyd
Mrs. A. M. Hansen

Emergency and Aids to General Chairman

Mrs. Benjamin H. Sherman, Chairman

Mrs. E. M Pallette
Miss Lillian Bellah
Miss Florence Burger
Mrs. Philip Stephens

VIII—RAILROAD INFORMATION*

May 9–13, 1938

Ticket agents of principal rail lines in California, on presentation and surrender of identification certificates, will sell round-trip tickets to Pasadena, California, costing approximately 1½c per mile, and the certificates which you may send for will show the convention fares that will apply to Pasadena from principal California points. Tickets will be sold from May 4 to 13, inclusive, and return limit will be May 23, 1938. Stopovers are allowed. If longer return limit is desired, consult railroad ticket agent at Pasadena prior to May 23, 1938.

Send a stamped, self-addressed envelope to State Secretary to secure a certificate in order to obtain convention rate.

Following are examples of *round-trip convention fares* from points named below to Pasadena, California, available on presentation of certificate:

Auburn	$15.05	Redding	19.05
Bakersfield	5.55	Sacramento	13.95
Barstow	4.00	Salinas	11.15
Calexico	7.50	San Bernardino	1.80
Chico	16.85	San Diego	4.10
El Centro	7.50	San Francisco	14.60
Eureka	23.60	San Jose	13.20
Fresno	8.80	San Luis Obispo	7.15
Los Angeles	.40	Santa Barbara	3.55
Marysville	15.55	Santa Cruz	12.30
Merced	10.45	Stockton	12.50
Modesto	11.60	Tulare	7.45
Redding	19.05	Visalia	7.75
Oakland	14.45	Woodland	14.50
Oroville	16.35	Yreka	23.10
Paso Robles	8.20		

MOTOR CAR ROUTES TO THE HUNTINGTON

From San Francisco:

Follow U. S. Highway No. 99 to State Highway 134 in Glendale. Turn left, follow State Highway 134, which is Colorado Street, in Pasadena. Continue to 800 block on East Colorado, where Oak Knoll Avenue intersects. Turn right on Oak Knoll to The Huntington, 1401 South Oak Knoll Avenue.

From Los Angeles:

Go out North Spring or North Broadway to end, which is Mission Road. Turn left on Mission Road to Huntington Drive, which is a continuation of Mission Road. Follow Huntington Drive to the 1,000 block in San Marino. Turn left on Oak Knoll Avenue to Hotel Huntington.

LOCAL TRANSPORTATION ON PACIFIC ELECTRIC RAILWAY

The out-of-town members who arrive in Los Angeles by train can reach the Hotel Huntington through the Red Cars—Pacific Electric railway, marked "Pasadena via Oak Knoll."

The cars on this route leave the Pacific Electric station on the southeast corner of Sixth and Main streets according to the schedule printed below. The time interval to reach the Hotel Huntington at the Hotel Huntington station in Pasadena is about forty minutes. The fare is 20 cents each way; round trip, 40 cents.

Time table at the date of this printing is as follows:

Leave	Los	Angeles	at..	6:02	a.m.	Leave	Los	Angeles	at..	3:50	p.m.
"	"	"	"	6:22	"	"	"	"	"	4:10	"
"	"	"	"	6:51	"	"	"	"	"	4:31	"
"	"	"	"	7:10	"	"	"	"	"	4:44	"
"	"	"	"	7:30	"	"	"	"	"	5:08	"
"	"	"	"	7:50	"	"	"	"	"	5:18	"
"	"	"	"	8:10	"	"	"	"	"	5:33	"
"	"	"	"	8:30	"	"	"	"	"	5:53	"
"	"	"	"	8:50	"	"	"	"	"	6:13	"
"	"	"	"	9:10	"	"	"	"	"	6:33	"
"	"	"	"	9:30	"	"	"	"	"	6:53	"
"	"	"	"	9:50	"	"	"	"	"	7:13	"
"	"	"	"	10:10	"	"	"	"	"	7:33	"
"	"	"	"	10:30	"	"	"	"	"	7:53	"
"	"	"	"	10:50	"	"	"	"	"	8:13	"
"	"	"	"	11:10	"	"	"	"	"	8:33	"
"	"	"	"	11:30	"	"	"	"	"	8:53	"
"	"	"	"	11:50	"	"	"	"	"	9:13	"
"	"	"	"	12:10	p.m.	"	"	"	"	9:33	"
"	"	"	"	12:30	"	"	"	"	"	9:53	"
"	"	"	"	12:50	"	"	"	"	"	10:13	"
"	"	"	"	1:10	"	"	"	"	"	10:33	"
"	"	"	"	1:30	"	"	"	"	"	10:53	"
"	"	"	"	1:50	"	"	"	"	"	11:23	"
"	"	"	"	2:10	"	"	"	"	"	11:53	"
"	"	"	"	3:30	"	"	"	"	"	12:23	a.m.

(First car leaves at 6:02 a. m., and last car at night leaves at 12:23 a. m. from Los Angeles for Pasadena.)

SOUTHERN PACIFIC TRAINS: NORTH AND SOUTH

Southern Pacific Trains arriving from San Francisco, pull into Los Angeles as follows:

"Lark" leaves San Francisco 9:00 p.m.; arrives in Los Angeles at 9:00 a.m.

"Sunset" leaves San Francisco 8:00 p.m.; arrives in Los Angeles at 8:10 a.m.

"Daylight" leaves San Francisco 8:15 a.m.; arrives in Los Angeles at 6:00 p.m.

"Coaster" leaves San Francisco 6:15 p.m.; arrives in Los Angeles at 8:00 a.m.

"Owl" leaves Oakland 6:30 p.m.; arrives in Los Angeles at 8:35 a.m.

On the return trip from Los Angeles to San Francisco, the trains leave and arrive at same time, reversing hours of departure and arrival.

IX—COMMERCIAL EXHIBITS

Aloe Company, A. S., 932 South Hill Street, Los Angeles. Booths Nos. 43 and 44.

Ayerst, McKenna & Harrison, Ltd., 781 Williams Street, Montreal, Canada. Booth No. 8.

Baxter, Don, Inc., 1505 Gardena Avenue, Glendale. Booth No. 45.

Benjamin Company, M. J., 323 West Sixth Street, Los Angeles. Booth No. 1.

Calso Company, The, 524 Gough Street, San Francisco. Booth No. 20.

Coca-Cola Company, The, Atlanta, Georgia. Booth No. 19.

Cutter Laboratories, Berkeley. Booth No. 29.

Dictograph Products Company, Inc., 457 Powell Street, San Francisco. Booth No. 18.

Doctors' Business Bureau, The, San Francisco and Los Angeles. Booth No. 46.

Emerson Drug Company, Baltimore, Maryland. Booth No. 26.

Heinz Corporation, H. J., 2998 San Pablo Avenue, Berkeley. Booth No. 27.

Hollister-Stier Laboratories, 2003 Wilshire Boulevard, Los Angeles. Booth No. 9.

Horlick's Malted Milk Corporation, Racine, Wisconsin. Booth No. 16.

Jones Metabolism Equipment Company, 1870 Ogden Avenue, Chicago, Illinois. Booth No. 15.

Kip Corporation, 919 East Pico Street, Los Angeles. Booth No. 4.

Lederle Laboratories, 450 Sutter Street, San Francisco. Booth No. 24.

Lepel High Frequency Laboratories, Inc., 39 West Sixtieth Street, New York, New York. Booth No. 17.

Liebel-Flarsheim Company, 303 West Third Street, Cincinnati, Ohio. Booth No. 33.

Magnuson X-Ray, 1814 Ninth Street, Los Angeles. Booth No. 39.

Medical Bureau (M. Burniece, director), Pittsfield Building, Chicago, Illinois. Booth No. 14.

Medical Protective Company, The, Wheaton, Illinois. Booth No. 23.

Morning Milk Company, Continental Bank Building, Salt Lake City. Booth No. 34.

Mosby Company, C. V., 3523 Pine Boulevard, St. Louis, Missouri. Booth No. 7.

Pet Milk Sales Corporation, St. Louis, Missouri. Booths Nos. 21 and 22.

Philip Morris & Company, Ltd., 119 Fifth Avenue. New York. Booth No. 5.

Scherer Company, R. L., 699 Sutter Street, San Francisco. Booths Nos. 2 and 3.

Stacey, J. W., Inc., Flood Building, San Francisco. Booth No. 30.

Stokely Brothers & Company, Inc., South East Street, Indianapolis. Booth No. 38.

Walters Surgical Company, 522 Sutter Street, San Francisco. Booth No. 12.

Western Surgical Supply Company, Ltd., 1926 Wilshire Boulevard, Los Angeles. Booth No. 40.

Zweegman School for Medical Secretaries, 450 Sutter Street, San Francisco. Booth No. 6.

* What is here given is printed for its general informative value. It is wise to check on your own ticket rates and time tables.

X—LOS ANGELES, PASADENA, AND HOTEL HUNTINGTON—OUR CONVENTION HOSTS

The members of the Los Angeles County Medical Association and its Pasadena branch unit are our hosts for our sixty-seventh annual session. They extend a cordial welcome to all members and bid them to come to this session that promises much through its official program and entertainment features.

A large volume could be written about our host association, the largest in membership in our State organization. This, however, is impossible at this time, and probably unnecessary. Unnecessary, because from time to time its organizational activities have been recorded in our journal. Again, many of our members have had occasion to enjoy attendance at meetings of this unit.

It is not amiss to state that it was the foresight of its officers and members that accomplished the erection and operation of its Association building at 1925 Wilshire Boulevard, and the eventual acquisition of nearly a quarter of a million dollars in property. From this central home the numerous activities of the County Association radiate. Mention is made of its library, café and dining room, its beautiful muraled auditorium and executive offices. The executive and administrative staff render valuable services in incalculable amount to every member. The twenty permanent standing committees concern themselves with the organizational problems of these times.

The twelve branch units and fifteen scientific sections provide programs and meetings of highest merit. The opinion is unanimous that our host unit is an outstanding medical unit not only in California, but also in the nation. The assurance can be given that its guests during this annual session will be the recipients of a most cordial welcome and gracious hospitality. The following constitutes its roster of officers for the current year: George H. Kress, president; Ralph B. Eusden, vice-president; George D. Maner, secretary-treasurer; S. K. Cochems, executive secretary; Fred B. Clarke, chairman of the Council; E. T. Remmen, vice-chairman of the Council; Donald J. Frick, chairman of the Board of Trustees.

The Pasadena branch is officered by: R. C. Olmsted, president; L. J. Brunie, vice-president; Lyle G. Craig, secretary.

This branch meets every third Tuesday in its own auditorium, which is comfortably furnished and has many rare and interesting pictures of outstanding medical men. Distinguished winter visitors frequently appear on its program.

The officers and members of the Pasadena branch will be particularly prominent in the rôle of hosts. Through them opportunities will be provided to visit points of interest that are the pride of the Pasadena area.

It can be safely asserted that all who attend this annual session will return home with many pleasant memories of profitable and enjoyable days amid these genial hosts.

FREDERICK C. WARNSHUIS.

HOTEL HUNTINGTON, PASADENA

The Huntington is internationally known and one of the leading resort hotels in America. It is famous for its beauty, hospitality, and excellent cuisine. The entire staff takes a personal interest in the success of each convention held here and assists in every way possible. There have been many conventions held here and they have all agreed that their Huntington convention was the finest their group had ever held.

ATTRACTIVE SETTING

Location and Grounds.—The Huntington is situated in its own thirty-acre park in the Oak Knoll residential district of Pasadena. It is but ten minutes from the business district of the city by street-car (the interurban line that runs between Pasadena and Los Angeles passes the hotel grounds) and but thirty-five minutes from the downtown section of Los Angeles. There are ample facilities on the grounds to keep your group entertained between meetings. There is a beautiful swimming pool in the midst of our Japanese Gardens and a barbecue pit at one end, which make it an ideal place to hold an alfresco supper or luncheon. Most organizations find the supper at the pool the most delightful affair of their whole convention. We also have tennis courts, badminton courts, a golf putting green, ping pong, and other attractions to keep you busy.

Accessibility.—The Santa Fe Railroad runs through Pasadena, and the station is about ten minutes from the hotel. The Southern Pacific and Union Pacific railroads do not come directly into Pasadena, the Southern Pacific station being at Alhambra, which is about fifteen minutes' drive; and the Union Pacific at East Los Angeles, which is about twenty to twenty-five minutes from the hotel. Both railroads, however, have a bus service and could arrange to transport you right to the hotel door. The Southern Pacific also has a station at Glendale which is quite convenient for those coming down from the North, especially if someone can drive over to that station and meet them. If that is not possible, they can go directly into Los Angeles and take the Pacific Electric from there right to the entrance of the Huntington grounds. Pasadena can be easily reached by any of the automobile routes.

Historical Background of Pasadena.—This part of the country has a wonderful historic background and within sight and easy reach of the hotel are many famous landmarks which were left by the Spaniards, who occupied this territory before it became part of the United States. About twenty-five minutes from here, for instance, is the San Gabriel Mission, which was founded by the Franciscan Padres during the time of the Spanish occupation. In the early days there were no towns, but just these two Missions, and it is interesting to note the number of cities that have grown up around these settlements. Pasadena, itself, is a word derived from the Chippewa Indian dialect, meaning "Crown of the Valley," and in 1770 Don Gaspar de Portola and his band of Spanish explorers camped here. They called this section San Pasqual, and it was not until 1875 that the present name was given the city. It was called Pasadena because it not only described the location of what was then a village overlooking the valley, but also because it was beautiful, musical, and euphonious—a reputation it has held to the present time. The city itself is a cultural center, and it is known the world over for its Tournament of Roses parade on New Year's Day and for the East-West football classic which is held in the Rose Bowl on the same day. The Tournament of Roses is a parade five miles in length, graced with floral tributes from cities all over the Pacific Coast. Some floats require one hundred thousand blossoms to decorate, and no artificial blooms of any kind are allowed to appear on the floats.

Henry E. Huntington Library and Art Gallery.—Within ten minutes of the hotel is the Henry E. Huntington Library and Art Gallery. This ranks among the world's greatest museums. It comprises about two hundred thousand rare books and more than a million and a quarter original manuscripts of very great money value. The Huntington Art Gallery contains the greatest of English portraits ever gathered under one roof. The collection is made up of forty-five paintings: forty-one portraits and four landscapes. The most famous painting in this collection is Gainsborough's Blue Boy, which was bought from the Duke of Westminster in 1921 for the sum of $640,000. Pinkie, the companion picture of the Blue Boy, is also on display at this gallery. When this marvelous collection was opened to the public, Mr. Huntington stipulated that there should be no charge of any kind made for admittance to the gallery or to the library. The only requisite is that reservations be made in advance, inasmuch as the number of people visiting the museum in any one day is limited, and they extend a very cordial invitation to groups such as yours to visit this art center, which is also one of California's garden spots.

California Institute of Technology.—The California Institute of Technology is also located within ten minutes of the hotel. Professors of international repute in the field of technical education and research gather here. The laboratories are equipped with the most modern instruments for scientific research. The million-volt electrical laboratory and the famous Guggenheim Aeronautical Experimental Station make a visit to this institution very interesting. Arrangements can be made for your group to see these special features, and some member of the faculty

will accompany you on their tour and give a little explanatory lecture which will make such a visit worth while. The 200-inch mirror is being ground there for use on Mount Palomar.

Mount Wilson Observatory.—Then, on the summit of mile-high Mount Wilson is situated the Mount Wilson Observatory of the Carnegie Institute of Washington, D. C. The world's largest telescope is located here, as well as a fine exhibition of astronomical photographs. A very interesting lecture is given on Friday nights and at that time visitors have an opportunity of looking through the telescope. From this point there is an excellent view of San Gabriel Valley and the coast line, as well as the lights of fifty-six cities in Southern California—a magnificent sight.

Other Attractions.—There are many interesting things to be seen in Pasadena; in fact, they are too numerous to mention. Among them are the Pasadena Community Playhouse, which is one of the most famous little theaters in the country; Mount Lowe; the Lyons Pony Express Museum, in which relics of early California life are housed. There is also the Civic Center, the Colorado Street Bridge, and many beautiful residential estates, as well as the Santa Anita Racing Park.

Picture Bridge.—One important sightseeing spot right on the Huntington grounds is the picture bridge, which has forty-one oil paintings showing typical landscapes and landmarks of California. For those who do not have an opportunity of taking a post-convention trip this will be a particular boon, for it will enable them to see California at a glance. This is a very unique feature as there is only one other bridge of pictures in the world, and that is the one in Lucerne, Switzerland.

Hotel Accommodations.—The Huntington, which is situated so near the populous center of Southern California is far enough away to afford all the advantages of a country resort combined with the conveniences of a city hotel. It maintains a quiet dignity. The spacious lobby, which is always cool, greets you upon entering the hotel with that luxurious atmosphere which makes you feel immediately at home. It overlooks the San Gabriel Valley with its Spanish type homes with red tile roofs, graceful eucalyptus trees, date palms, peppers, and oaks as well as our own horseshoe gardens. It is indeed a delightful place to gather for a bridge tea, reception, or chat before dinner. Our rooms are all outside rooms, facing the Sierra Madre Mountains on the north and overlooking the San Gabriel Valley on the south. Each room or suite has its own private bath. There are six sleeping floors and, of course, elevator service.

The main dining room is large enough to seat nine hundred for dinner. It is an extremely attractive room, with a very high ceiling and is decorated in green and gold. It lends itself beautifully to any floral decorations, and table flowers are really all that is necessary. It is lined on either side by windows looking out upon the patio, the Japanese Gardens, and the swimming pool. The acoustic properties are splendid and, inasmuch as the floor is completely carpeted, there would be no disturbance or noise from persons walking around the room. There are alcoves on either side of the room in which our regular guests usually sit when a convention is in session. Other rooms are large enough for special luncheons, dinners, or meetings. These rooms seat from fifteen to one hundred for a meal, or twenty-five to one hundred seventy-five for a meeting.



Fig. 2.—Aeroplane view of the Huntington Hotel showing a portion of the twenty-nine acre grounds.

Part II

PRE-CONVENTION BULLETIN*

FOREWORD.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations of these reports, and to discuss them with other members and delegates.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the House of Delegates and the Members of the California Medical Association:

Your President intends to transmit his official observations and recommendations to the House of Delegates and the membership at large in his addresses to the House of Delegates, and before the first general meeting.

During the year, in so far as it was possible for me to accept, I have visited, in company with councilors and general officers, or alone, some eleven county societies. I have also attended every meeting of the Council and the Executive Committee.

Respectfully submitted,
Howard Morrow, *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

Your President-elect has attended all meetings of the Council and Executive Committee, and has cared for such committee work as has been assigned to him; and, in company with other officers of the Association, he has visited all the county units in Southern California.

He is most appreciative of courteous and cordial expressions of good will that have been extended to him.

We will all look forward to a happy year of service in behalf of organized medicine in its local, state and national units.

Respectfully submitted,
W. W. Roblee, *President-elect.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

During the past year your Speaker has attended all meetings of the Council and the Executive Committee, of which bodies he is, ex officio, a member. He has performed such special committee duties as have been assigned to him and, in company with the President-elect, Secretary, and Councilors, has visited most of the societies in the southern counties.

The House of Delegates will convene promptly at 8 p. m. on Monday, May 9. Its second meeting will be on Wednesday, May 11. The Speaker urges all delegates to be in their seats at the hour of convening, and takes this occasion to remind the delegates that they have assumed very serious duties in accepting office. These duties are not to be taken lightly, and, even though some small personal sacrifice is demanded, the responsibility of a delegate is such that the inconvenience to himself is to be borne as the price of his office.

The Speaker wishes also to urge all delegates and alternates to read the Pre-Convention Bulletin carefully in order that they may be familiar with the work and the problems of their organization.

Respectfully submitted,
Lowell S. Goin, *Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

In order that the Council may present to the House of Delegates a report that embraces all of its official actions up to the time that the House of Delegates convenes, the annual report of the Council will be presented at the first meeting of the House of Delegates.

Respectfully submitted,
Morton R. Gibbons, *Chairman.*

REPORT OF SECRETARY-TREASURER

To the President and the House of Delegates:

In submitting this annual report for 1937 to the Council and, through it, to the members of the Association, I desire to first express a very genuine appreciation to all the officers and members who have contributed so freely to make possible the accomplishments of the past year. Generous credit is given to committees and officers of county units who have given of their time, energy and experience. Unity of action, with a common desire to attain the purposes of organization, has made it possible for our Association to experience a most successful year as is revealed in this report of stewardship.

MEMBERSHIP

The Association's numerical strength is recorded in the following tabulation:

MEMBERSHIP AS OF DECEMBER 15, 1937

Organized	County	No. Members 1936	No. Members 1937	New	Delinquents
1902	Alameda	476	515	37	12
1903	Butte	24	23	2	3
1903	Contra Costa	49	50	0	3
1902	Fresno	112	117	8	0
1903	Humboldt	30	34	4	0
1903	Imperial	27	26	0	1
1902	Kern	48	50	4	2
1903	Kings	15	17	1	4
1914	Lassen-Plumas-Modoc	11	14	3	0
1871 1902	Los Angeles	2,200	2,357	148	50
1902	Marin	40	41	1	0
1903	Mendocino-Lake	19	23	5	1
1903	Merced	28	28	3	3
1903	Monterey	51	57	3	5
1903	Napa	34	36	2	0
1902	Orange	109	113	10	5
1889 1903	Placer	30	35	2	0
1902	Riverside	69	70	5	6
1902	Sacramento	143	148	9	1
1904	San Benito	7	6	0	1
1902	San Bernardino	137	146	17	8
1902	San Diego	258	274	23	9
1902	San Francisco	812	831	59	14
1902	San Joaquin	98	107	12	3
1903	San Luis Obispo	29	26	3	3
1905	San Mateo	58	63	6	1
1902	Santa Barbara	102	104	9	3
1902	Santa Clara	171	171	9	2
1903	Santa Cruz	30	32	3	1
1903	Shasta	15	17	2	2
1916	Siskiyou	15	15	1	0
1905	Solano	26	27	2	1
1903	Sonoma	54	49	1	5
1906	Stanislaus	40	42	2	1
1906	Tehama	11	9	0	1
1906	Tulare	38	35	2	2
1903	Ventura	35	33	2	3
1903	Yolo-Colusa-Glenn	26	27	4	1
1903	Yuba-Sutter	15	16	1	0
		5,492	5,784	407	155

Active Members	5,784
Associate members	5
Retired members	63
Honorary members	2
Total	5,854

Number of members died in 1937 75

* Section 3, Article XII, of the California Medical Association Constitution states, in part: "The Association, prior to the annual session, shall print a 'Pre-Convention Bulletin,' which shall contain reports of officers and committees. . . . A copy of the 'Pre-Convention Bulletin' shall be given to each delegate and alternate on or before registration."

COUNCILOR DISTRICTS

FIRST DISTRICT—SQUARE MILES, 36,376

Calvert L. Emmons, Councilor, Ontario

County	1936	1937	New	Delinquent
Imperial	27	26	0	1
Orange	109	113	10	5
Riverside	69	70	5	6
San Bernardino	137	146	17	8
San Diego	258	274	23	9
	600	629	55	29

SECOND DISTRICT—SQUARE MILES, 4,115

Carl R. Howson, Councilor

County	1936	1937	New	Delinquent
Los Angeles	2,200	2,357	148	50

THIRD DISTRICT—SQUARE MILES, 15,800

Louis A. Packard, Councilor

County	1936	1937	New	Delinquent
Kern	48	50	1	4
San Luis Obispo	29	26	3	3
Santa Barbara	102	104	9	3
Ventura	35	33	2	3
	214	213	15	13

FOURTH DISTRICT—SQUARE MILES, 17,042

Axcel E. Anderson, Councilor

County	1936	1937	New	Delinquent
San Joaquin	98	107	12	3
Fresno	112	117	8	0
Kings	15	17	1	4
Merced	28	28	3	3
Stanislaus	40	42	2	1
Tulare	38	35	2	2
	331	346	28	13

FIFTH DISTRICT—SQUARE MILES, 7,556

Alfred L. Philips, Councilor

County	1936	1937	New	Delinquent
Monterey	51	57	3	5
San Benito	7	6	0	1
San Mateo	58	63	6	1
Santa Clara	171	171	9	2
Santa Cruz	30	32	3	1
	317	329	21	10

SIXTH DISTRICT—SQUARE MILES, 42.19

Karl L. Schaupp, Councilor

County	1936	1937	New	Delinquent
San Francisco	812	831	59	14

SEVENTH DISTRICT—SQUARE MILES, 1,466

Oliver D. Hamlin, Councilor

County	1936	1937	New	Delinquent
Alameda	476	515	37	12
Contra Costa	49	50	0	3
	525	565	37	15

EIGHTH DISTRICT—SQUARE MILES, 28,617

Fred N. Scatena, Councilor

County	1936	1937	New	Delinquent
Butte	24	23	2	3
Yolo-Colusa-Glenn	26	27	4	1
Lassen-Plumas-Modoc	11	14	3	0
Placer	30	35	2	0
Sacramento	143	148	9	1
Shasta	15	17	2	2
Yuba-Sutter	15	16	1	0
Tehama	11	9	0	1
	275	289	23	8

NINTH DISTRICT—SQUARE MILES, 23,255

Henry S. Rogers, Councilor

County	1936	1937	New	Delinquent
Humboldt	30	34	4	0
Marin	40	41	1	0
Mendocino-Lake	19	23	5	1
Napa	34	36	2	0
Siskiyou	15	15	1	0
Solano	26	27	2	1
Sonoma	54	49	1	5
	218	225	16	7

Comment.—In December, 1936, our membership in good standing numbered 5,492. At the close of the present year there is recorded a membership of 5,854, a *net gain* of 362, and a *gross gain* of 605. A delinquency of 155 for the year, which since the books have been closed, on December 20, has been *reduced* to 104, is most pleasing. The summarization, therefore, is that at the close of the year our membership totals 5,901.

There can no longer be any question of the declaration that the California Medical Association, with over 85½ per cent of licensed, eligible, resident physicians enrolled as members, *is* the representative organization and spokesman of the medical profession of California.

During 1937, seventy-five members responded to their last call. Their names are recorded in our archives associated with memories of their deeds of service and charity:

Edgar William Alexander, San Francisco
Luis Ferdinand Alvarez, Los Angeles
William Gillispie Attwood, Los Angeles
Charlotte LeB. J. Baker, Point Loma
Chester D. Ball, Orange
W. Jarvis Barlow, Los Angeles
John Edwin Beck, Tulare
Mabel T. Bell, Ventura
Marie Antoinette Bennette, San Bernardino
Fred Phelps Bowen, Los Angeles
Walter Vernon Brem, Los Angeles
Harry V. Brown, Glendale
Newbern N. Brown, Bakersfield
James L. Busby, Pasadena
Henry B. Carey, San Francisco
John I. Clark, Orange
Harry Carson Coe, Oakland
Claire H. Denman, Berkeley
Alfred J. Downs, Los Angeles
Albert Knight Dunlap, Sacramento
Irving H. Eddy, Glendale
James A. Ellis, Alameda
Etta Farmer, Sacramento
William Edward Fehliman, Santa Cruz
Joseph C. Friedman, Banning
Willis LeF. Gatchell, Butte, California
David Garrison Ghrist, Los Angeles
Hannah A. Goodridge, San Jose
Frank Pierce Gray, San Francisco
Louis D. Green, San Francisco
John D. Grissim, Oakland
Harold G. Gross, Eureka
Emil O. Hay, Sacramento
John Randolph Haynes, Los Angeles
William T. Heffernan, Imperial
Edgar H. Howell, San Francisco
Leonard Charles Hull, Hollister
Charles Breckenfeld Jones, Sacramento
Edwin Frank Kehr, Carmel
Bert C. Kern, Jackson
Walter D. Lenker, San Bernardino
Melbourne Mabee, Santa Ana
James G. Martin, Long Beach
Frank W. Miller, Los Angeles
Harold A. Miller, Alameda
William P. Millspaugh, Los Angeles
Andrew J. Minaker, San Francisco
Thomas William Moffitt, Hollywood
George Thomas Mountford, Coalinga
Philip Newmark, Los Angeles
T. C. O'Connor, Jr., Murphy
Margaret R. Otis, Los Angeles
John Thomas Peery, Corcoran
John F. Pruett, San Francisco
Thomas Rea, Yreka
Carl Renz, San Francisco
George Henry Roth, Los Angeles
Charles Wesley Rook, Montrose
James W. Seawell, Sonoma
Harlan Lewis Smith, Fair Oaks
Munford Smith, Los Angeles
R. Knight Smith, San Francisco
Jacobus C. Solomon, Los Angeles
John C. Spencer, Palo Alto
William Earnshaw Styan, San Francisco
Earl Bertrand Sweet, Los Angeles
Frank D. Sweet, Long Beach
Richard F. Tomlinson, San Francisco
Dwight Howe Trowbridge, Fresno
J. Russell Van Sickle, Santa Monica
Lyman Trevitt Wade, San Luis Obispo
Albert Samuel Wall, Los Angeles
Oran Lamar Webster, Holtville
Joseph Sully Wheeler, Santa Cruz
Daniel Webster Zirker, Merced

Our sympathies embrace all those in the homes of these departed members.

FINANCES

The following statement of resources, income, and expenditures, as certified to by our licensed, bonded public accountants, transmits a summary of the year's financial operations:

INCOME AND EXPENDITURES

CALIFORNIA MEDICAL ASSOCIATION

For the period December 19, 1936, to December 18, 1937

INCOME

Dues and General

Membership dues	$84,494.75	
Exhibits at annual meeting	5,175.00	
California Medical Society—Services	600.00	
Interest earned	445.41	
Miscellaneous	72.77	
		$ 90,787.93
Official Journal—California and Western Medicine		
Advertising	$26,645.95	
Subscriptions	581.39	
Reprint sales	2,799.31	
Addressograph income	136.23	
Miscellaneous—Recoveries on accounts previously written off	85.68	
		30,248.56
		$121,036.49

EXPENDITURES

Administrative	$29,357.25	
Scientific, educational and public relations	16,461.74	
Official journal—California and Western Medicine	40,414.35	
Legal	4,576.71	
		90,810.05
Net income		$30,226.44

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EXPENDITURES

CALIFORNIA MEDICAL ASSOCIATION

For the period December 19, 1936, to December 18, 1937

ADMINISTRATIVE

Salary—Secretary-Treasurer and Director of Public Relations	$12,000.00	
Salaries—clerical	3,700.00	
		$15,700.00
Travel expense:		
Secretary-Treasurer and Director of Public Relations	1,022.15	
Council	1,166.08	
Executive Committee	255.30	
American Medical Association delegates	1,318.95	
		3,762.48
Rent		3,288.00
Annual meeting expense		2,568.97
Office supplies and expense		1,197.15
Telephone and telegraph		980.19
Postage		461.48
Office equipment		56.80
Council general expense		203.32
Annuities for employees		200.00
Miscellaneous		938.86
		$29,357.25

SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS

California Medical Economic Survey expense	$ 5,290.94	
Contributions to medical libraries	2,723.50	
Legislation and public policy expense	3,909.84	
Public relations—Clerical salaries	1,071.90	
Committee on scientific work	558.93	
Postgraduate instruction	440.82	
Cancer Commission expense	135.60	
Other committee activities	2,330.21	
		16,461.74

OFFICIAL JOURNAL—CALIFORNIA AND WESTERN MEDICINE

Printing	$24,459.55	
Salary—Editor	4,000.00	
Salaries—Clerical	3,560.00	
Advertising commissions	3,690.29	
Cost of reprints	2,365.09	
Distribution expense	1,203.06	
Discounts and collection expense	280.63	
Office supplies and expense	620.13	
Addressograph cost	154.14	
Provision for doubtful accounts	77.00	
Miscellaneous	4.50	
		40,414.35

LEGAL

Retainer fees	$ 4,000.00	
Extra fees	200.00	
Miscellaneous expenses	376.71	
		4,576.71
Total		$90,810.05

* * *

BALANCE SHEET

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

December 18, 1937

ASSETS

Cash			
On deposit:			
Commercial account:			
Bank of America N. T. & S. A.		$ 559.27	
Savings accounts:			
Crocker First Federal Trust Co.	$2,028.99		
Bank of America N. T. & S. A.	933.61		
The San Francisco Bank	728.05		
		3,690.65	
			$ 4,249.92
Marketable Securities			
U. S. Government securities—at cost (quoted market prices—$53,342.51)			49,306.25
Other Assets			
Loans to California Medical Association		$31,000.00	
Accrued interest on bonds		1,149.42	
Accrued interest on savings accounts		75.65	
			32,225.07
			$85,781.24

LIABILITIES

Members' contributions to Endowment Fund—Note A			$ 200.00
Net Worth			
Contributed Surplus			
Received from California Medical Association		$75,000.00	
Earned Surplus			
Balance, December 19, 1936	$8,926.30		
Net income for period December 19, 1936, to December 18, 1937	1,654.94		
		10,581.24	
			85,581.24
			$85,781.24

Note A—Contributions to an endowment fund for the purpose of providing income for the California Medical Association are being tentatively accepted, subject to return to contributors in the event that the amounts finally received do not warrant the establishment of such a fund.

* * *

INCOME AND EXPENDITURES

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

For the period from December 19, 1936, to December 18, 1937

INCOME

Interest on bonds	$1,494.02	
Interest on savings accounts	191.42	
		$1,685.44
EXPENDITURES		
Miscellaneous		30.50
NET INCOME		$1,654.94

Comment.—A net operating gain of $30,226.44 for the year is quite gratifying. This has been accomplished by constant alert supervision. Economy in administrative costs in the amount of some $15,000 instituted during the last two years have been continued. Additional savings of some $3,500 was accomplished during the last year. This economy has by no means limited or hampered any of the Association's functions or activities. Income earnings, outside of annual dues, have been increased by obtaining greater advertising revenue, sale of exhibit space, lessened cost of commissions and the assuming of work that would have required added expense had it been delegated to others.

Unpredictable, but imperative, expenses to the amount of $6,238.14, decreased what otherwise would have been a larger net operating gain for the year.

The governing budget is closely adhered to. The Auditing Committee approves all accounts every month before vouchers are issued. Vouchers are signed by the chairman and the secretary-treasurer. A copy of the monthly balance sheet and statement is sent to every general officer and councilor each month. Association expenditures and reserves are safeguarded and carefully administered.

CALIFORNIA AND WESTERN MEDICINE

Under the able editorship of Dr. George H. Kress, our official publication continues its prestige in the field of medical journals. Grateful acknowledgment is made to the editor for many gracious courtesies and ever willing helpfulness in supervising the business details of publication.

Advertising income was $26,645.95. An average of 6,300 copies were mailed each month. Included in this number are the complimentary copies sent to officers and members of the House of Delegates of the American Medical Association.

Additional comment upon our JOURNAL will be made in the editor's annual report.

ASSOCIATION ACTIVITIES

A studious endeavor has been made each month to report through the medium of our official journal upon the activities of the Council, Executive Committee, and the work of standing and special committees. The purpose being to keep all members abreast with the affairs of the Association and the representation that was being made on behalf of all members. Therefore, at this time, only brief summaries will be recorded for the purpose of recapitulation.

(a) *Annual Conference of Officers, Councilors, County Secretaries, and Standing Committees.*—This was held in October in San Francisco. An innovation was introduced by the presence of those who constitute the membership of standing and special committees. The value of these annual conferences has been attested to by the attendants' comments published in the November and December issues of the JOURNAL. These conferences afford opportunity for better conception of Association policies and problems and inspiring a unity of action in the attainment of desired organizational objectives. There can be no sound solution of any problem without a clear understanding of its nature and portent; hence these informative conferences are of great value and justify the expense involved.

(b) *Postgraduate Program.*—An outstanding expanding Association activity is the Five-Year Postgraduate Program as announced in the Supplement to the November issue of CALIFORNIA AND WESTERN MEDICINE. The foreword in that supplement is explanatory of this Association function and should be referred to.

Program arrangements and the holding of these conferences are under way. Further report will be made to the House of Delegates by the committee.

The details of application and conducting of these sessions places a very greatly increased correspondence responsibility upon the secretary's office that will eventually require the services of a full-time stenographer.

(c) *Public Health Education.*—The secretary's office has arranged several series of educational lectures, and demonstrations for lay organizations that evoked much favorable comment. For the coming year, many such series have been scheduled for Young Women's Christian Associations, Women's Clubs, and Parent-Teacher Association organizations, and other such lay groups.

Your secretary considers this to be an important educational function, and when sound public and private opinion is engendered in regard to questions of public and private health, misunderstandings will disappear and people will no longer be misled by those who prey upon and profit from public lack of understanding of laws governing human health and health welfare. It is purposed to expand this educational activity. The creating of public good will is most vital to our interests.

(d) *Public Contacts.*—Contacts have been established, maintained, and continued with representatives of departments of state and county governments, boards of commerce, and trade, dental, hospital, and nursing organizations, Young Women's Christian Association, Federation of Women's Clubs, Parent-Teacher Association, Safety Council, Forestry Service, trade groups, and similar representative bodies. Daily, many letters of inquiry have been received from these groups, to which prompt answers are sent. Cordial relations are being fostered, and public confidence is being created by these contacts.

(e) *Committees.*—All possible assistance has been rendered to all committees and all the facilities of the headquarters office have been placed at their disposal to aid in every possible way in bringing about the greatest results from committee activities.

(f) *Annual Session.*—Appraisal of each annual session rests with the officers and members. It may be assumed, from expressions and records of attendance, that each annual session is productive of distinct benefits to all participants.

The selection of a meeting place that provides satisfactory and adequate accommodations is becoming, or rather is, a serious question. Increased attendance, larger section and general meetings, expanding technical and scientific exhibits, cause some of the accustomed meeting places of former years to now be inadequate. Your secretary presents a recommendation at the conclusion of this report upon this subject.

(g) *County Charters and Constitutions.*—A survey revealed that a majority of the county units were not in possession of charters. These were lost through changes in county officers and failure to transfer official records. Under Council action, new charters have been issued. Several counties were without constitutions and by-laws, and steps were taken to have them adopt new constitutions and by-laws conforming to the provisions of the Association's Constitution and By-Laws.

(h) *Subscriptions to Medical Libraries.*—A contribution of $2.723 was made to the Lane and the Los Angeles County Medical Libraries.

(i) *Visits to County Societies.*—During the year your secretary has, either in company with President Morrow, President-Elect Roblee, Speaker Goin, Councilor of the District, or alone, attended meetings of the following county societies: Orange, Riverside, San Bernardino, Imperial, Sacramento, Merced, Kings, Monterey, Salinas, Pasadena, Solano, Napa, Sonoma, Kern, Fresno, Contra Costa, Humboldt, and Marin. At these "Association Nights," informative discussions are had upon Association and county questions that are of vital interest to every doctor.

These meetings serve also to cement our constituent units into a state organization with common interests and purposes with central headquarters. Their value is further evidenced by our increased membership, sustained county activity, and interest and live-going units.

In addition, your secretary has attended and participated in meetings of: State Tuberculosis Association; State Safety Council; American Legion; Golden Gate International Exposition; Young Women's Christian Association; Annual conference of State Secretaries; Parent-Teachers Association; Association of American Medical Colleges; State Hospitals Association; State Nurses Annual meeting. Every opportunity was embraced to develop good will and coöperation with these several influential groups. Many citations could be made of the value of these contacts which are self-evident.

(j) *Association Headquarters.*—These are the headquarters of every member, and your secretary seeks to cause it to so serve. Official records are carefully kept and important data are secured and made available for reference. A daily average of one hundred letters are received and answered. An average of six personal interviews per day are had with members, students, visiting doctors, and lay persons. Some days as many as fifteen persons have called. These visits are welcomed and establish a central office, where dependable information may be secured. Likewise, many telephone calls of inquiry are answered each day. No effort is made to tabulate the number of these letters, visits, or telephone inquiries, which amount into the thousands and consume the time of all the office personnel.

Appreciation is sincerely expressed for the loyal, devoted services of all the office personnel. They have been faithful to the duties imposed upon them.

RECOMMENDATIONS

The following recommendations, or rather suggestions, merit consideration and decision.

1. The designation of a central meeting place where adequate accommodations and facilities are available to meet the needs of the annual sessions merits investigation and report to the House of Delegates at a future date.

2. More aggressive action to acquire a permanent endowment fund.

3. That consideration be again given to the acquiring of a permanent headquarters owned by the Association. It may be possible to finance such purchase with the use of a minimum of reserve funds and a Federal Housing loan over a period of ten or fifteen years. Our Association should be housed in permanent headquarters.

CONCLUSION

It can be confidently affirmed that the Association's house is well in order. As an organization, its purposes and policies are sound and consistent. Those who are vested with stewardship and administration have met up to the responsibilities reposed in them, and justifiable pride may be expressed by reason of the record made during the past year and the consummation of constructive endeavor. With confidence instilled by all that the past has wrought, the prediction is warranted that the coming year will witness still greater progress, further reaching expanding activities, and a leadership that will redound to glory of the membership and of benefit to the citizens of California and to the members of the Association.

In concluding this report, your secretary desires to express his deep appreciation for the assistance, consideration, and guidance accorded him by the House of Delegates, the Council, and the membership at large. I am sincerely grateful for having the privilege to serve, which I have sought to do to the best of my ability, and for the best interests of all.

Respectfully submitted,
Frederick C. Warnshuis, *Secretary.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

The editor's report on papers received, printed, awaiting publication, or declined, is as follows:

(a) *Report on papers of the annual session at Del Monte, May, 2-6, 1937:*

At last year's annual session a total of 152 papers were read before the general meetings and different sections.

A summary of the disposition of the papers read at that year's annual session is as follows:

Del Monte annual session papers published in 1937	25
Del Monte annual session papers published in 1938	13
Del Monte annual session papers read, but published elsewhere, declined or not sent in	66
Del Monte annual session papers in CALIFORNIA AND WESTERN MEDICINE files still awaiting publication (annual session papers in this April issue to be deducted)	48
Total annual session papers read at Del Monte	152

(Note: Del Monte annual session papers to appear in the May issue will further reduce the list of unpublished papers.)

(b) *Report on special articles which have been printed in* CALIFORNIA AND WESTERN MEDICINE *during the period April, 1937 to April, 1938 inclusive:*

Special and original articles which were published in CALIFORNIA AND WESTERN MEDICINE during the past year (April, 1937 to April, 1938 inclusive) are as follows:

Section papers from annual session at Coronado, 1936	19
Section papers from annual session at Del Monte, 1937	38
Papers read before general sessions at Del Monte, 1937	4
Lure of Medical History articles	15
Papers read before county and other medical societies	3
Papers accepted from miscellaneous sources (original articles, abstracts of speeches, reprints from other publications, etc.)	18
Clinical Notes and Case Reports	30
Editorials	51
Editorial Comment articles	39
Bedside Medicine symposia	12
Special articles	80
Total papers published during past year	309

(c) *Report on manuscripts in* CALIFORNIA AND WESTERN MEDICINE *files and awaiting publication in April, 1937, and later issues:*

Unpublished papers from annual session at Del Monte (not counting papers to appear in May issue)	48
Unpublished papers read before county and other societies	2
Unpublished papers not read before other societies	13
Lure of Medical History articles	9
Clinical Notes and Case Reports	25
Editorial Comment articles	20
Bedside Medicine symposia	4
Total manuscripts on hand, awaiting publication	121

(d) *Report on non-annual session papers submitted:*

A total of thirty-three papers from county societies and other sources, which were submitted for publication in CALIFORNIA AND WESTERN MEDICINE during this past fiscal year (April, 1937 to April, 1938 inclusive), could not be accepted for various and special reasons.

Non-annual session papers submitted, but declined	33

Comment.—During recent years the official publications of the constituent state medical associations of the American Medical Association have been conforming, one by one, and more and more, to a pattern in which the organization work of the state and component county societies is receiving increased attention and space. The explanation for this is that the many medical-economic problems, which have been constantly coming to the front in recent years, have made it necessary for publication committees to respond to the interests of readers by supplying, in each issue, accurate information on community, state, and national public health and medical practice problems. This new outlook on state medical society journalism has necessitated a departure from the former somewhat stereotyped magazines containing some original articles and editorials on scientific subjects, with a limited amount of space for local items, and it is to the credit of the official journal of the California Medical Association that its founder-editor, the late Philip Mills Jones, some thirty-six years ago was among the first to sense these newer conditions that had thrust themselves upon medical practice. His *Journal of the Medical Society of the State of California* (former name of CALIFORNIA AND WESTERN MEDICINE) presented in general format the style now in use by our own and by an increasing number of state medical publications.

Your editor, naturally, is in full accord with the pattern and division of contents, which, for the last few years, has been found in each issue of CALIFORNIA AND WESTERN MEDICINE, and the members of the Publication Committee assume that the typographical and other set-up must be satisfactory as a desirable and convenient arrangement, since practically no criticisms or suggestions for change have been called to their attention. No apology is made for the space devoted to organization matters, because the understanding of medical-economic issues is today of paramount importance if the scientific interests of the profession and the public health responsibilities of the State are to be safeguarded and promoted. These facts are particularly pertinent in relation to the official journals of state medical societies.

However, in placing emphasis upon medical-economic and organization work, CALIFORNIA AND WESTERN MEDICINE has not neglected the promotion of scientific topics, and it is gratifying to know that the subject matter presented by contributing members measures up to standards that compare favorably with the best in medical literature, with especial reference to the interests and needs of physicians in general practice.

During the last year the experiment of supplements, to cover what are practically reference monographs, has been tried, and it is our impression that these additions to the regular issues have commended themselves to readers.

The sorrow that comes each year, with the advent of each annual session, is the realization that, owing to lack of space, so many of the more technical papers must be released for publication elsewhere. In a large society such as the California Medical Association, there is, however, no other alternative. Essayists who are on the annual session program, and whose papers are of a specialized

nature and who would prefer appearance in a technical journal, are requested to make early requests for release to print elsewhere.

In conclusion, the editor wishes to again thank contributors and the many members of the Association who have so generously responded when called upon for discussions, and other comment and aid. It is our continued ambition to have CALIFORNIA AND WESTERN MEDICINE reflect the highest credit upon the California Medical Association and its members.

Respectfully submitted,
George H. Kress, *Editor.*

REPORT OF THE LEGAL DEPARTMENT

To the President and the House of Delegates:

Events have moved rapidly during the past year, and an unusual number of legal matters have come before the Association since the last report of this department.

In order not unduly to extend this report, only a brief review of the more important phases of the past year's work will be undertaken.

Corporate Practice.—This department's reports for the years 1935 (CALIFORNIA AND WESTERN MEDICINE, May, 1936, page 412), and 1936 (Supplement to CALIFORNIA AND WESTERN MEDICINE, April, 1937, page 42), summarized the decisions in *Pacific Employers' Insurance Company* vs. *Insurance Commissioner,* and *Benjamin Franklin Life Insurance Company* vs. *Insurance Commissioner.* These cases, each decided by a District Court of Appeal, in our opinion firmly establish the California law to be that a corporation cannot directly or indirectly practice medicine or surgery. In addition to the foregoing cases, the legislature in 1937 enacted the Business and Professions Code, several sections of which codify the rule forbidding corporate practice of medicine. It is believed that these sections are of such vital importance to the medical profession that they ought to be quoted in full herein:

2006. The term "person" means a natural person when a right, privilege or power is conferred by this chapter upon a person.

2007. The term "professional" relates to the art and science of medicine and surgery and to such other arts and sciences as may be included within the field of medicine and surgery.

2008. Corporations and other artificial legal entities have no professional rights, privileges or powers.

These three sections are, in effect, a legislative declaration of the public policy which forbids corporations to practice by any means the profession of medicine and surgery.

There is now pending before the California Supreme Court an action entitled *People of the State of California on the Relation of the Board of Medical Examiners* vs. *Pacific Health Corporation.* In this case the Attorney-General has taken the position that the activities of the Pacific Health Corporation constitute, in effect, the practice of medicine by a corporation. Acting pursuant to direction of the Council, we prepared an exhaustive brief upholding the position of the Attorney-General and filed it with the Supreme Court. The court took the matter under submission several months ago, and early in January set aside its order of submission, stating that no four members of the court could agree upon a decision. The case is now again on the calendar for oral argument. The Pacific Health Corporation has argued that its activities do not infringe upon the rule of law forbidding the corporate practice of medicine. The corporation's brief before the Supreme Court contains the statement that:

We do not contend that a corporation can actually or legally practice medicine or any other profession.

In other words, the corporation candidly states that it would be illegal for it to engage in the practice of medicine or surgery.

County Hospitals.—During the past year this department has endeavored to be of full assistance to the special committee on county hospitals, of which Dr. Louis A. Packard is the chairman, and your General Counsel has attended several meetings of this committee, held in San Francisco and Los Angeles. Many legal problems have arisen in connection with this subject, some of them of such a complex nature that a great deal of time has necessarily been spent by the committee and the Council in their consideration.

Proposed Basic Science Law.—Acting pursuant to instructions of Dr. George H. Kress, General Chairman of the Committee on a Basic Science Law, this department reviewed in detail the various drafts of a proposed initiative and prepared for the members of the Council and the committee a detailed memorandum discussing and explaining all of the legal points which appeared to us to be necessarily involved in the proposed basic science initiative. At the present time this department is, pursuant to instructions, working upon a proposed constitutional amendment to be discussed and possibly submitted to the legislature at its next session. It is believed that in a short time it will be possible to submit to the committee a preliminary and tentative draft of a proposed constitutional amendment which will include all of the provisions which have been agreed upon as necessary in any workable basic science legislation.

Los Angeles County Medical Association By-Laws.—Some time ago it was determined by the Los Angeles County Medical Association to revise its by-laws in order that they might be more appropriate for government of the largest component county society. Dr. Edward M. Pallette, Chairman of the Committee on Revision of the By-Laws, requested your General Counsel to assist it in its labors. Inasmuch as the Los Angeles County Medical Association is an incorporated organization, there were a number of technical legal problems confronting the Committee on Revision of the By-Laws. The magnitude of the task which confronted this committee is difficult to describe and cannot be visualized unless one has had personal experience in similar undertakings.

Therefore, it is believed that the excellent code of by-laws which resulted from the labors of the committee, with the legal assistance of this department, is one of the most important and at the same time more satisfactory accomplishments of the past year.

Medical Jurisprudence Column.—As stated in the report of this department last year, a column in CALIFORNIA AND WESTERN MEDICINE, entitled "Medical Jurisprudence," was created by the Council in 1936. During the past year, articles on medical, legal, and other topics of interest to the medical profession have been prepared for this column. The articles in Medical Jurisprudence have been selected from among the subjects which have tentatively been decided upon for inclusion in the proposed Physicians' Handbook. It is the intention of your General Counsel that in the near future a preliminary draft of the Physicians' Handbook may be prepared, using much of the material that has appeared from month to month in the Medical Jurisprudence column. Comments and suggestions of members of the Association, with respect to this column and to the Physicians' Handbook, are cordially invited.

Physicians' Handbook.—As stated under the previous heading, the contemplated Physicians' Handbook is in process of preparation. Your General Counsel, Secretary-Treasurer, and Editor are endeavoring to carry out the directions of the Council and to that end have prepared a tentative outline of the subjects to be included in the handbook and, as above stated, various preliminary drafts of particular subjects have been prepared and printed in CALIFORNIA AND WESTERN MEDICINE, under the heading "Medical Jurisprudence."

Workmen's Compensation Case.—The Council, at its fall meeting, authorized your General Counsel to appear before the California Supreme Court in an action entitled *Pacific Employers' Insurance Company* vs. *Industrial Accident Commission and Kenneth Tator.* Pursuant to the Council's authorization, your General Counsel and Mr. Howard Hassard, one of his associates, appeared before the Supreme Court during oral argument of the case and subsequently prepared and filed a written memorandum of points and authorities on behalf of several physicians who had rendered professional services to Kenneth Tator. This proceeding involved the following question: Where an employee employed in Massachusetts by a Massachusetts employer is injured while temporarily in California on a special job for the employer, and is treated by California

physicians, can the injured employee recover compensation and the physicians a reasonable fee for their services in California, or must both the injured employee and his physicians proceed therefor in Massachusetts? Before the Supreme Court this department argued that it would be against the public policy of this State to require its physicians to go elsewhere to recover the reasonable value of their services. The Supreme Court, speaking through Mr. Justice Douglas L. Edmonds, agreed with our position and decided the case in favor of the injured employee and his attending physicians.

Malpractice Insurance. — Early last fall a number of different types of Lloyd's of London malpractice insurance policies were being issued throughout the State to members of the Association. The legal department received literally hundreds of inquiries from Association members with respect to Lloyd's of London and malpractice insurance generally. A preliminary investigation established that there were at that time at least thirty different kinds of malpractice insurance contracts being issued in the name of Lloyd's of London and that no two of these contracts were alike, some being adequate as to legal form and others obviously affording incomplete protection to the insured.

At the same time requests for assistance were received from several county societies, and in endeavoring to aid these societies, particularly the San Francisco County Medical Society, a model form of Lloyd's of London malpractice insurance policy was eventually prepared.

At the request of the Executive Committee of the Council, a further survey of the entire malpractice field was made and a formal report was presented to the Council at its meeting of January 15, 1938. In this report a brief résumé of the American insurance companies writing malpractice insurance was made and a detailed review of the various surplus line brokers representing underwriters at Lloyd's in London was presented. Since that report your General Counsel has been informed that one of the few American companies writing malpractice insurance has retired from the field. Your General Counsel has also recently been informed that the surplus line brokers in California through their own association have agreed to adopt the Lloyd's of London policy form prepared and approved by this department, and it is said to be their intention to use it exclusively so that in the future all Lloyd's of London malpractice insurance policies will be uniform. It is to be hoped that this information is accurate and will prove to be the fact.

The tremendous amount of research and correspondence carried on by the legal department in the past year on the subject of malpractice insurance is difficult to summarize in this report. Your General Counsel has been requested to, and will, present a full report on this subject to the House of Delegates at its first meeting at Pasadena. Interested members of the Association are also referred to the various reports on malpractice insurance which have been published or will be published in California and Western Medicine, the *Bulletin of the Los Angeles County Medical Association*, and the *Bulletin of the San Francisco County Medical Society*.*

Miscellaneous.—During the past year, opinions have been requested and furnished dealing with such subjects as California Unemployment Reserves Act, the legal and ethical aspects of certain types of group medical practice, the legal scope of the practice of chiropractic, the legal status of methods of operation of county hospitals in effect in several of the counties, and many other subjects. Under instructions from the Council, this department has undertaken the defense of physicians who have been sued for damages as a consequence of testifying in a criminal prosecution based upon the alleged unlawful practice of medicine.

Attendance at conferences of officers at meetings of the Council, Executive Committee, and other standing and special committees, has been maintained throughout the year.

Members of this department have also enjoyed meeting with the members of a number of the county societies, where matters of legal import were considered.

Respectfully submitted,

Hartley F. Peart, *General Counsel.*

* See California and Western Medicine, February, 1938, on page 148, and March, 1938, on page 226.

II

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

Annually each councilor is expected to report to the President and the House of Delegates regarding conditions pertaining to medicine and surgery in his district.

The First Councilor District is third in number of members and first in geographical boundaries. The counties of Imperial, San Diego, Orange, Riverside, and San Bernardino comprise the First Councilor District.

There have been no serious problems before the members of this district during the past year. County Hospital admissions and management have been quite satisfactory to all concerned. The sick and needy have been well cared for by the medical fraternity, and as far as I can gather from many individual contacts, all the men have had a more profitable year than the previous one. Hospital insurance carriers have not invaded the First District to any degree. Each county has seen many new and young men enrolled in the county societies. Few desirable men remain out of the county societies' enrollments.

The State officers, President-Elect Roblee, Speaker of the House of Delegates, Lowell Goin, and Secretary Warnshuis, have visited all the county societies at regular or called meetings and have given them very profitable talks on society matters which ended in round-table discussions for all present.

Postgraduate courses have taken on an added interest this year as evidenced by the Riverside meeting held on February 14. The men are interested in the clinical presentation of the various subjects. The Orange County Postgraduate Conference will be held on March 15 at 4 p. m. at the Ebell Club in Santa Ana. The San Bernardino conference will follow on April 7 at 4 p. m. at the Elks Club in San Bernardino.

Respectfully submitted,

Calvert L. Emmons, *Councilor, First District.*

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

During the past year steady progress has been made in the growth of the Los Angeles County Association.

The outstanding accomplishment was the drafting and adoption of a new constitution and by-laws. These represented many hours of unselfish labor on the part of the committee which had charge of the revision. In several respects they radically changed our former set-up.

For many years the specialty sections and the geographical branches have had representatives on the Board of Councilors. Because of the great disparity in membership in these various groups, it was realized that this caused definite inequalities of representation. It also made for a rather large deliberative body. A further difficulty arose from the fact that many of these representatives were elected for only one year, with the inevitable result that the greater part of their term of office was occupied in becoming familiar with the organization machinery.

In order to remedy these defects, a Council of twenty-one members has been created, each holding office for a period of three years, their terms being staggered so that seven new members are elected each year, thus making for a preponderance of experienced men and insuring continuity of policy.

Similarly, the five members of the Board of Trustees hold office for five years, with a change of one member each year. It is felt that the longer terms of office for the trustees are in keeping with the financial responsibility which devolves upon this Board.

The by-laws provide for the creation of twenty-one committees, each committee designed to study a present-day problem. It is also the idea that these committees will afford an opportunity for many members to become familiar with our problems and in this way new blood will be constantly introduced and be available for the administrative

work of the organization. Several of these new committees are already extremely active.

The other outstanding feature of the by-laws is the incorporation in its entirety of the recently adopted disciplinary code of the California Medical Association.

The effect of these changes will be greatly to increase the efficiency and smooth working of the organization.

Respectfully submitted,

Carl R. Howson, *Councilor, Second District.*

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, and Ventura Counties

To the President and the House of Delegates:

The councilor of the Third District has made the customary visits to the component societies. In addition, Santa Barbara, Ventura, and San Luis Obispo counties were hosts at special meetings to President-Elect Roblee and Secretary Warnshuis. Kern County was visited, at its annual banquet, by Doctors Roblee, Goin, and Warnshuis.

All societies in the district are functioning in excellent condition. The San Luis Obispo County Society is especially to be commended for the manner in which it handled its county hospital crisis.

The first postgraduate conference in the district was arranged for March 12 and 13 at Santa Barbara. The committee responsible for this conference is to be congratulated for the work done in its preparation and the excellent program arranged. In spite of various stormy weather there were 110 registered, which exceeded the expectation. The District is already looking forward to next year's conference.

Respectfully submitted,

Louis A. Packard, *Councilor. Third District.*

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mono, Mariposa, Inyo, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

Adjustment of some difficulties among members attending Council meetings, promotion of postgraduate conferences and Woman's Auxiliary activities, visits to county medical societies, meetings with the Farm Bureau and other lay organizations in the interest of our organization, and committee work on the County Hospital problem, were some of the activities by which the Councilor has tried to serve the district and the California Medical Association during the past year.

The attention of the membership has been pointedly directed to the importance of conscientious observance of the ethics of the profession and avoiding those errors in deportment which may furnish pretexts for malpractice suits. Adequate professional liability insurance has been a matter of much concern, in view of the alarming increase of suits. The standard form of policy developed by the California Medical Association's legal department and furnished by acceptable underwriters has been explained as offering the best solution of this problem at present.

An expression of majority opinion from constituent societies on expenditures in connection with the proposed basic science initiative was obtained and voted in the Council.

Some progress is being made in the spread of voluntary insurance in this district, but not in sufficient volume as yet to encourage the belief that it will to any great extent solve the problems of our needy sick. Other means to supplement voluntary insurance seem required in this district to offset the ever growing demand of taxpayers and nonindigents for the privilege of hospitalization in tax-supported institutions.

This being the year of another general election, the continuous interest in candidates for county supervisors and members of the legislature has been urged on the membership, and the need of hearty coöperation with our organizations of defense against measures designed to obstruct medical research and practice has been brought to the attention of our county societies.

The profession in general throughout the district is in full accord with the activities of the California Medical Association and is rendering excellent medical service, much of which is donated to the public, and is supporting public health measures that are constantly encroaching on the field of medical practice.

Respectfully submitted,

A. E. Anderson, *Councilor, Fourth District.*

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

There have been several instances of notable achievement by the county medical societies in the Fifth Councilor District during the past year. Coöperating with the California Tuberculosis Association, the members of the San Mateo County Society have made possible more extensive school surveys which in themselves have proved valuable and are a means of furthering the effort toward control of tuberculosis in that county. A similar program has been started in Santa Cruz County and has already made progress.

Santa Clara County Medical Society has adopted basic principles for the coördination of its members and the County Hospital in the venereal disease campaign.

San Benito County Medical Society has expressed great interest in a proposed postgraduate program in this district in the near future.

All county societies in the district have been visited at least once, and plans have been made for additional visits with our State Secretary before the annual meeting.

Respectfully submitted,

Alfred L. Phillips, *Councilor, Fifth District.*

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

The major interest of the members of the Sixth District during the past year has been further study of health and hospital insurance and a thorough study of malpractice insurance.

In the matter of health and hospital insurance our particular efforts have been directed toward working out a plan which will provide a health service for the municipal employees of San Francisco. After many conferences, and after destructive criticism of certain plans, and after the presentation of three plans of our own, we have finally agreed upon one which, we feel, assures proper service to the insured by a physician of the insured's own choice and will, after the first year of operation, give reasonable compensation to the physician for that service.

The subject of malpractice insurance was very carefully surveyed by a committee, of which Dr. Philip K. Gilman is chairman and to which our legal counsel, Hartley F. Peart, was adviser. This has been an outstanding piece of work, and as a result a very satisfactory policy was made available just at the time when another major company withdrew from the field.

We feel that real progress has been made in our district this year.

More detailed reports on the above activities appear in California and Western Medicine.

Respectfully submitted,

Karl L. Schaupp, *Councilor, Sixth District.*

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

The Alameda County Medical Association has held ten regular meetings during the year, with scientific programs prepared and presented, in large measure, by our membership. One visiting speaker was included.

The Alameda County Medical Association shows steady increase in membership, and the past year, like the years preceding it, has added forty-two members to our number, twenty-nine of which were elected to regular membership, and thirteen to junior associate membership. The Association lost, through resignation, death, and failure to pay

dues, twenty-four members during the year, leaving a net gain of sixteen members.

During the year our Council was honored by a visit from Dr. Olin West, Secretary of the American Medical Association, and a special luncheon meeting was held for Doctor Leland, Director of the Bureau of Economics of the American Medical Association.

Progress can be reported in the development of our Hospital Insurance plan. The project is now fifteen months old, and during that period has shown a uniform and highly satisfactory growth in the number of policyholders and in more perfect understanding of the underlying problems by those entrusted with its management. One important feature has been the opening of the plan to members of the families of the present policyholders, on a financial basis which makes it highly attractive. The premium of the original policyholders is ninety cents, that of the spouse eighty cents, and each dependent child forty cents. This is a long step toward making the plan popular and a satisfactory solution of the problem of the general public in paying hospital costs. The plan is operating in four counties, and has added to its personnel an advisory committee of outstanding lay citizens from each of the four counties. The enthusiasm of this group is most encouraging to all interested in the success of the project.

Contra Costa County has joined with Alameda County in the Hospital Insurance plan, and is progressing as well as could be expected at this time. The Contra Costa Medical Society's regular meetings are well attended, and there are but few eligible men in the county who are not members of the Society.

Respectfully submitted,

O. D. Hamlin, *Councilor, Seventh District.*

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

During the first half of the present term, Dr. C. E. Schoff served as councilor for this district, and during this period he and several of the California Medical Association officials have made visits to many of the local societies. Doctor Schoff reports that all the meetings were well attended, and that the scientific programs were well presented.

The only accomplishment during my short term has been the reëstablishment of the Intercoast Hospitalization Insurance Association on the approved list of the California Medical Association. The controversial points have been cleared away and perfect understanding now exists.

Respectfully submitted,

F. N. Scatena, *Councilor, Eighth District.*

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Mendocino, Lake, Marin, Napa, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

The hardest part of the year's work is preparing the councilor's annual report, as it is impossible to set forth the amount of work accomplished in the various society visits and the multiplicity of details attended to in such a brief report.

It is gratifying to see the intense interest the members of the county societies now take in the activities of organized medicine, as against the apathy and general spirit of do nothing that existed when I first began making councilor visits some years ago. Whether this intense interest is due to the present type of editorials in the JOURNAL, the annual Secretaries' Conference, or the present unrest, is hard to analyze, but I believe the annual mid-year Secretaries' Conference is producing results.

During the past year I have attended all Council meetings, visited all of my societies but one, and to the best of my ability promoted the interest of organized medicine in this district.

Respectfully submitted,

Henry S. Rogers, *Councilor, Ninth District.*

III

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

During the past year we have attended a number of meetings having to do with the activities of the Association.

The Secretaries' meeting was well attended, and I was impressed with the interest which members of the profession, from one end of the State to the other, are taking in matters pertaining not only to scientific medicine, but to economic phases of the practice of medicine. This increased coöperation on the part of many physicians who formerly took only a casual interest in the work of organized medicine, should be reassuring to all of us.

Respectfully submitted,

W. H. Kiger, *Councilor-at-Large.*

To the President and the House of Delegates:

All of the meetings of the Council have been attended, and an attempt has been made to acquaint the local society with what is going on throughout the State.

Respectfully submitted,

C. O. Tanner, *Councilor-at-Large.*

To the President and the House of Delegates:

Circumstances beyond control and of professional moment to me prevented my attending the last annual session and the meeting of the Council in January, 1938. All other meetings of the Council recorded my attendance. In official capacity, I have attended numerous conferences and hearings that dealt with activities of the city employees of San Francisco, designed to establish a health service for this group.

I have also attended many meetings of the Advisory Committee to the Hall of Science of the Golden Gate International Exposition.

Considerable time has also been devoted to the work of the Legislative Committee and to matters related to malpractice insurance.

Respectfully submitted,

T. Henshaw Kelly, *Councilor-at-Large.*

To the President and the House of Delegates:

As councilor-at-large my time has been almost wholly occupied by duties of the Committee on Public Policy and Legislation. Talks on legislation and legislative trends have been given, both at home and at the neighboring component societies, in company with Dr. F. C. Warnshuis, as he made his visits to the county groups.

Respectfully submitted,

Junius B. Harris, *Councilor-at-Large.*

To the President and the House of Delegates:

Our president and our secretary and councilors who preside over councilor districts will, without doubt, report of their activities, with inadequate emphasis on the time which they have given to the California Medical Association.

This Councilor would invite the attention of the members of the Association to the extraordinarily full coöperation of all Association officers.

Special meetings have been attended, on short notice, and without complaint.

Committee work has been undertaken and completed with care and precision.

Regular meetings have been fully attended.

The interest, energy, and loyalty of all your officers are commended to your attention.

Respectfully submitted,

M. R. Gibbons, *Councilor-at-Large.*

To the President and the House of Delegates:

It has been my privilege, during 1937, as a councilor-at-large, to assist in bringing about an agreement between the Board of Directors of the Associated Hospital Service of Southern California and the medical profession, acting

through the Los Angeles County Medical Association, which eliminated the chief difference in policy and procedure that constantly occurs when lay-controlled organizations enter into the rendering of a professional, or semi-professional, service.

In this instance the fine spirit of coöperation on the part of the representatives of the Associated Hospital Service of Southern California brought about the elimination from their contracts and certificates of agreements to render any and all professional services, including laboratory and x-ray procedures. This agreement follows the definition of the House of Delegates of the American Medical Association as to what constitutes hospital service and, in my opinion, is the only safe method whereby prepayment of hospital service, where solicitation of the beneficiaries occurs, may be carried on that should receive the approbation and support of the medical profession without the danger of encroachment upon professional privilege by lay corporations.

As your councilor-at-large I have maintained a constant affiliation with other groups in the community in order that I might bring a comprehensive knowledge and viewpoint into the meetings of the Council, to assist in the answering of our continuously changing problems. The immediate future will present problems that concern the medical profession in their relationship to the public that will require a broad and deep understanding of the trend of the times in order that we attempt to adjust our relationship on a basis that will permit us to continue to serve, free from restrictions and interference that would decrease the quality of service that is the motivating ideal of every man in the medical profession.

Respectfully submitted,

Harry H. Wilson, *Councilor-at-Large.*

IV

REPORTS OF STANDING COMMITTEES

EXECUTIVE COMMITTEE

Karl L. Schaupp, Chairman

Howard Morrow, President.
William W. Roblee, President-elect.
Edward M. Pallette, Past President.
Lowell S. Goin, Speaker, House of Delegates.
Morton R. Gibbons, Chairman of the Council.
Karl L. Schaupp, Chairman, Auditing Committee.
Charles A. Dukes, Chairman, Committee on Public Relations.
Frederick C. Warnshuis, Secretary-Treasurer.
George H. Kress, Editor.

To the President and the House of Delegates:

The Executive Committee of the Council has met monthly during months for which Council meetings were not scheduled.

The Executive Committee concerns itself with Association policies and work and indicates action as questions arise concerning the Association's interests. Nine officers and councilors contribute their time and judgment in establishing supervision of Association matters.

Thus, questions and representations are promptly considered, eliminating delay and expediting prompt action to the advantages of all members.

Digests of its meetings are published, and at each Council meeting action is taken to cause the minutes to become part of the Council's record.

The Executive Committee diligently seeks to discharge its duties, and account for its stewardship.

Respectfully submitted,

Karl L. Schaupp, *Chairman.*

AUDITING COMMITTEE

Executive Group

Karl L. Schaupp, Chairman

O. D. Hamlin T. Henshaw Kelly

To the President and the House of Delegates:

In compliance with the provisions of the by-laws, we shall submit a draft of the 1938-1939 budget at the opening session of the House of Delegates.

Respectfully submitted,

Karl L. Schaupp, *Chairman.*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

John V. Barrow, Chairman, 1940

Edwin L. Bruck, 1938 W. H. Geistweit, 1939

To the President and the House of Delegates:

The work of the committee has been done chiefly by correspondence. Each member has been asked to render a report to be incorporated in the committee report. The dentists, the druggists, and certain officers of the Bar Association, together with an important insurance company, have all been contacted regarding a campaign for the listing of voters.

The plan involves the listing and classification of the physicians of the State Medical Association. These groups will contain from ten to thirty, as convenience dictates. A leader, responsible to the County Association, will have direct telephone contact with each member. Each physician will be requested to furnish names and addresses of his patients who, by virtue of their confidence in him, will support the legislative measures that our State Association recommends. This method alone will yield better than 500,000 votes. The Woman's Auxiliary has signified its willingness to make these listings through our county medical associations. This entails an enormous amount of work, which they are capable and happy to do.

Not many letters need to be mailed, but the one final request direct to the voter must be signed by the physician himself. Whether these letters are mailed through the county medical associations, or the State Medical Association office, or the League of Public Health, is for the determination of the Council. We particularly request the approval of the Council for the Auxiliary coöperation in this matter. The same organization can be accomplished in the allied organizations without forming any legal tie-up.

Doctor Geistweit of San Diego has done much work with the local pathologists and other physicians in the matter of the new law licensing laboratory workers. He recommends a more careful and thorough study of this situation than has been given heretofore. He has also done some work in the line of his convictions that there should be a much stronger law licensing nurses, in which matter he recommends that that subject be studied by our committee.

Locally, and in matters of the State, we have coöperated with the Auxiliary with the greatest pleasure and our best ability.

Respectfully submitted,

John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

Fred B. Clarke, Chairman, 1938

W. R. P. Clark, 1939 Benjamin W. Black, 1940

To the President and the House of Delegates:

It is quite apparent to the members of this particular Standing Committee that progress in the field of public health education is dependent upon persistent persistency. Your committee is also of the opinion that visualization of a subject or health fact is the most effective means of educating the public upon health matters.

Your committee has, through the offices of the State Secretary, pursued such a course during the past year. Several series of from three to six public lectures have been arranged for Y. W. C. A. groups, Women's Clubs, and High Schools. Gratifying expressions of appreciation have been received in return.

Some twenty-two lectures have been arranged for other lay groups during the past year. These engagements have inspired other groups to sponsor public meetings and enabled the making of new contacts that will record an expanding program of public education which can be assured by persistency in follow-up work.

Your committee deplores the lack of interest and coöperation on the part of county society members in this program of public education. Lack of interest is also manifested by many local health officers. Except for three or four exceptions, county societies and health officers are wholly disinterested. This lack of interest and seeming unwillingness on the part of members to prepare talks on health questions

and accept engagements to address lay meetings materially delays and limits the work of this committee.

Your committee respectfully submits the following recommendations:

1. That the House of Delegates direct each county unit to sponsor two or more public meetings each year, under the direction of a special local committee charged with this duty.

2. That these county committees be requested to enroll from their members a speakers' group and submit their names and subjects to the State Secretary. Members of these groups to be assigned to address lay meetings in their immediate vicinity.

3. That county or local health officers be requested to take suitable steps to sponsor and support public meetings for the purpose of public health education.

Respectfully submitted,
Fred B. Clarke, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Frank R. Makinson, Chairman, 1938
A. Elmer Belt, 1940 — J. Marion Read, 1939
The Secretary, ex officio — The Editor, ex officio

To the President and the House of Delegates:

The committee met once during the year. The meeting was held in San Francisco in October, 1937, when all the members were present. The work that had been accomplished was reviewed, but special attention was given to formulating a plan embracing the entire State.

It was considered advisable to suggest to the Council that the committee be enlarged and divide the State into districts so that one member of the committee would be responsible for obtaining the history in his particular district.

Death notices and obituaries were to be obtained and forwarded to California and Western Medicine, which has been satisfactorily carried out.

Requests were to be made of various public libraries of the State to set aside, in a place reserved for such, all books and articles pertaining to California medical history.

It is urged that a county historian be appointed by each component county unit; this has been done in several instances. A splendid appeal was made recently by the editor of California and Western Medicine along this line. A great deal has been accomplished toward collecting the history of the Association, but a still larger portion remains unfinished; yet satisfactory progress can be reported.

Appended hereto is a list of members who during the last year have been called from earthly labors to have their names recorded in the roster of the Chapter Eternal.

Respectfully submitted,
Frank R. Makinson, *Chairman.*

IN MEMORIAM

Alexander, Edgar William, July 21, San Francisco.
Alvarez, Luis Fernandez, May 24, Los Angeles.
Attwood, William Gillispie, July 14, Los Angeles.
Baker, Charlotte LeB. Johnson, October 31, Point Loma.
Ball, Charles Dexter, June 16, Santa Ana.
Barlow, W. Jarvis, September 4, Los Angeles.
Beck, John Edwin, April 8, Tulare.
Bell, Mabel T., September 27, Ventura.
Bennette, Marie Antoinette, July 27, San Bernardino.
Bowen, Fred Phelps, October 9, Los Angeles.
Brem, Walter Vernon, November 19, Los Angeles.
Brown, Harry V., June 26, Glendale.
Brown, Newbern N., May 30, Bakersfield.
Busby, James L., February 23, Pasadena.
Carey, Henry Benjamin, February 4, San Francisco.
Clark, John I., November 3, Santa Ana.
Coe, Harry Carson, June 11, Oakland.
Denman, Claire H., January 12, Berkeley.
Downs, Alfred J., March 12, Los Angeles.
Dunlap, Albert Knight, January 19, Sacramento.
Eddy, Irving Herbert, March 8, Glendale.
Ellis, James A., May 1, Alameda.
Farmer, Lydia Etta, July 1, Folsom City.
Fehliman, William Edward, November 24, Santa Cruz.
Friedman, Joseph C., October 20, Banning.
Gatchell, Willis LeForrest, December 31, Stockton.
Ghrist, David Garrison, February 3, Los Angeles.
Goodridge, Hannah A., October 26, San Jose.
Gray, Frank Pierce, June 28, San Francisco.
Green, Louis David, January 14, San Francisco.
Grissim, John D., July 22, Oakland.
Gross, Harold G., October 28, Eureka.
Hay, Emil O., October 15, Los Angeles.
Haynes, John Randolph, October 30, Los Angeles.
Heffernan, William T., December 30, San Diego.
Howell, Edgar Henry, December 30, San Francisco.
Hull, Leonard Charles, November 23, Hollister.
Jones, Charles Breckenfeld, March 14, Sacramento.
Kehr, Edwin Frank, October 31, Pasadena.
Kern, Bert C., September 5, Jackson.
Lenker, Walter Dora, January 30, San Bernardino.
Mabee, Melbourne, March 23, Santa Ana.
Martin, James J., March 23, Long Beach.
Miller, Frank W., November 1, Los Angeles.
Miller, Harold A., August 13, Alameda.
Minaker, Andrew J., January 16, San Francisco.
Millspaugh, Willard P., October 29, Los Angeles.
Moffitt, Thomas William, January 4, Hollywood.
Mountford, George Thomas, May 2, Coalinga.
Newmark, Philip, August 20, Los Angeles.
O'Connor, Thomas C., Jr., January 13, Lodi.
Otis, Margaret R., September 21, Los Angeles.
Peery, John Thomas, September 27, Corcoran.
Pruett, John F., March 17, San Francisco.
Rea, Thomas, December 1, Yreka.
Renz, Carl, January 22, Mill Valley.
Rook, Charles Wesley, April 15, Montrose.
Roth, George Henry, August 22, Los Angeles.
Seawell, J. Walter, December 26, Healdsburg.
Shidler, George P., September 12, Torrance.
Smith, Harlan Lewis, March 12, Fair Oaks.
Smith, Munford, June 28, Los Angeles.
Smith, R. Knight, April 18, San Francisco.
Solomon, Jacobus C., March 15, Los Angeles.
Spencer, John Campbell, July 4, Palo Alto.
Styan, William Earnshaw, November 24, San Francisco.
Sweet, Earl Bertrand, May 22, Los Angeles.
Sweet, Frank D., January 24, Long Beach.
Tomlinson, Richard Frank, March 13, San Francisco.
Trowbridge, Dwight Howe, May 4, Fresno.
Van Sickle, J. Russell, January 16, Santa Monica.
Wade, Lyman Trevitt, April 11, San Luis Obispo.
Wall, Albert Samuel, September 9, Los Angeles.
Webster, Oran Lamar, July 31, Holtville.
Wheeler, Joseph Sully, July 23, Santa Cruz.
Zirker, Daniel Webster, October 25, Merced.

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

Executive Group

Daniel Crosby, Chairman, 1939
Karl L. Schaupp, 1940 — George Dawson, 1938

To the President and the House of Delegates:

Although the year has been filled with many questions concerning hospitals, methods of conducting hospital insurance, and the like, nothing has come to the attention of this committee which required any action.

Most of the questions that have been given consideration have been considered by the Public Relations Committee.

Respectfully submitted,
Daniel Crosby, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Morton R. Gibbons, Chairman, 1938
Harry E. Zaiser, 1940 — Philip Stephens, 1939

To the President and the House of Delegates:

Attention has been called in the official journal of the California Medical Association to the decision of the Supreme Court of California in the case of *Tator* vs. *Pacific Employers' Insurance Company.*

"The court, in its decision, established that the California Industrial Accident Commission has jurisdiction over all injuries arising in this State, even though the contract of employment was made in another state and even though the employee is only temporarily assigned to work in this State. This obviates any possibility of physicians being required to proceed in other states for compensation for services performed in this State to an employee injured in this State."

The American Medical Association has organized a Council on Industrial Health. There has been one organization meeting. Another will be held before the California Medical Association annual session.

It is not possible to publish a statement regarding the proposed activities and scope of this Council in this bulletin. However, it is probable that definite information may be available before May 9.

The San Francisco County Medical Society has taken measures to secure from the Industrial Accident Commission of California, by means of the facilities of the WPA, statistics on industrial accident practice, and compilation of experiences in that practice. The data to be sought is under consideration, and suggestions from interested members is solicited by the committee of the San Francisco County Medical Society.

Respectfully submitted,

Morton R. Gibbons, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

George G. Reinle, Chairman, 1938
Fred R. De Lappe, 1939 John P. Nuttall, 1940

To the President and the House of Delegates:

Your Committee on Medical Defense, by the authority of Chapter 5, Section 4, of the by-laws, appointed an Advisory Committee, consisting of Dr. Phillip Gilman, Dr. Stanley Mentzer, and Dr. Gordon MacLean, to assist it in the preparation of a report on malpractice in California.

This committee begs to submit to the House of Delegates of the California Medical Association the following report and recommendations:

The committee has been informed that a number of surplus line brokers were engaged in writing physicians' defense and indemnity insurance contracts on behalf of different groups of underwriters at Lloyd's in London, England. The committee also found that surplus line brokers are authorized by the California Insurance Code to issue contracts of insurance in any particular field after it has been determined by the Insurance Commissioner that less than 50 per cent of the authorized and admitted insurers doing the particular class of insurance business involved (in this case liability insurance) are refusing to issue insurance contracts of the type sought to be issued by the surplus line brokers.

With respect to those insurance companies authorized to transact a liability insurance business in the State of California, the committee found the following: the Medical Protective Company of Fort Wayne, Indiana, issues physicians' defense and indemnity policies to members of the California Medical Association only, at the rate of $32 per annum and with a coverage of $5,000 to $15,000, but excludes the following:

(*a*) Most surgery, unless done in an emergency;

(*b*) Any liability growing out of the ownership, operation and supervision of any x-ray equipment for therapeutic work; or

(*c*) Any liability arising out of the ownership, operation, and supervision of any hospital, sanitarium or clinic, or any business enterprise. Upon payment of a premium of $48 per annum the company will remove the surgery restriction. In other words, a surgeon must pay $48 per year for coverage of $5,000 to $15,000. It appears that the Medical Protective Company will insure against liability arising from the use of x-ray equipment for therapeutic work at a premium of not less than $150 for the minimum coverage.

The Zurich General Accident and Liability Insurance Company, Ltd., according to the committee's information, will issue physicians' indemnity policies in certain instances. But the committee is also informed that the Zurich will not issue a policy to a physician who is not a member of his county society and the State Association, and even though a physician is a member of his state and county societies the company exercises a rigid selection. This company is not at all anxious to enter the malpractice field on a large scale.

There may be other insurance companies authorized to do business in California which will write malpractice policies, but your committee is not aware of their identity.

The large number of surplus line brokers representing various groups of underwriters located at Lloyd's in London, England, who are engaging in the malpractice insurance business in this state, are not so well known to the medical profession nor are their policies, or, in fact, the very nature of Lloyd's insurance.

Lloyd's is divided into many groups of underwriters, each operating independently of the other. In California these groups are represented by approximately thirty-seven agencies known as "surplus line brokers." Insurance agents in the various towns and cities of the State place the insurance of their clients (*i. e.,* physicians) with the surplus line broker. In insurance terminology the insurance agent is known as the "producer," and the surplus line broker is often referred to as the "broker," "underwriter," or "agent." (Mr. Hartley F. Peart, attorney for the California Medical Association, advises that this language utterly disregards the legal distinction between an "agent" and a "broker.")

The various Lloyd's groups (often referred to as "underwriters"), each acting for itself, prepare so-called underlying contracts by the terms of which the particular group authorizes specified agents (surplus line brokers) in various parts of the world to issue contracts of insurance to individuals in the name of "Lloyd's of London." Each member of the underwriting group signs his name to this underlying contract and indicates after his name the proportion of the total liability which may be incurred on all of the insurance contracts ultimately issued which he agrees to be personally responsible for. Copies of this underlying contract are then made available to the agents of the particular underwriting group all over the world. Acting pursuant to the authority contained in an underlying contract, surplus line brokers in California issue and sign malpractice insurance contracts bearing the name "Lloyd's of London."

The question of placing malpractice insurance with surplus line brokers representing underwriting groups at Lloyds in London, England, is a serious and immensely complicated problem. In addition to the problems created by the very nature of Lloyd's there are the legal problems which exist as a consequence of Lloyd's being situated several thousand miles away from the State of California.

Finally, one San Francisco broker submitted a policy form to the committee for its approval or disapproval. This form was submitted to Mr. Peart with the request that he review it. On his recommendation, your committee expressed its approval of this particular policy.

Your committee is informed that within the past two months a number of surplus line brokers issuing Lloyd's of London policies have revised their policy forms to conform with the policy form prepared under the direction of Mr. Peart and approved by your committee. At the present time it is believed that most policy forms now being issued in this State are, in substance, identical with the form which your committe has approved, but it has been impossible to verify this in all instances. Therefore, and in order that no misunderstanding may arise, your committee recommends that an expression of approval or disapproval be withheld with respect to malpractice insurance policies issued in the name of Lloyd's of London for the time being so that your committee and Mr. Peart may have an opportunity fully to verify the information concerning uniformity of policy forms.

The growth of malpractice claims has become a serious problem, and one which the medical profession must face and solve. Just why the problem has grown more acute in recent years cannot be said with certainty; but we can indicate, as the result of our investigations, the course that must be pursued if the growing evil is to be checked.

Some investigators have pointed out the increase has kept pace with the therapeutic use of radium and the roentgen ray. The development of surgery has received a share of the blame. Well founded or not, there is food for thought in the fact many insurance companies operating in this field charge higher premiums for policies written for surgeons, roentgenologists, and radiologists than for policies written for general practitioners.

Your committee strongly recommends that consideration be given to the study of the causes of malpractice claims as outlined by the Medical Defense Committee of the Los Angeles Medical Society. They are:

1. Ill-timed and critical remarks, innuendoes, and inferences by other doctors.

2. Emotional resentment on the part of patients, parents, and friends accompanying tragedy, injury, and accident, which is concentrated upon the doctor, often without reason.

3. Ill-timed and poorly conceived advice from legal, interested parties.

4. Inadequate, inaccurate, unscientific clinical and hospital records.

5. Submission by attorneys of description of the treatment rendered, to another member of the medical profession, who will examine it critically and point out one or two phases wherein he (the critic) would have done differently. The plaintiff's lawyer then immediately seizes upon this information and alleges that in those items the defendant was negligent.

6. Lack of information on the part of the public as to what actually constitutes malpractice.

It is further recommended that there be appointed in every county medical society a medical defense committee whose duties shall be, whenever a malpractice claim is made or threatened, to investigate the case and advise as to its handling in coöperation with all those concerned. In this connection your committee submits the following recommendations:

1. It shall be the policy of this committee and of the component county society to respect the privilege of every member to testify in any case as his conscience and opinion may dictate, and the committees shall not seek to prevent any member from so doing. It shall in all manner act with due regard to the rights of the patient.

2. Whenever this committee is informed that a claim of malpractice is made or threatened, the chairman or secretary shall, as soon as possible, summon a meeting of the committee for the purpose of investigating the circumstances connected with the case.

3. It shall be the duty of every member of the component county society to notify the chairman or secretary of this committee of any malpractice claim made or threatened against him, or against any other member of the profession, and to appear before this committee at any time when he may be called and give the committee all the information he may possess regarding the case.

4. It shall be the duty of every member of this Association who contemplates participation in the preparation of a malpractice claim or suit or testifying in any such suit, to first notify the Medical Defense Committee of his intentions and give his reasons therefor.

5. No member of this Association shall make a charge for services or accept any compensation for acting with regard to a malpractice claim. It is the policy of this Association that no member shall speak disparagingly of the treatment given by any other member until he has made himself thoroughly familiar with all the circumstances as they existed at the time the treatment was rendered.

Your committee wishes to emphasize the fact that the difficulty in getting an acceptable policy in California, due to mushroom growth of malpractice suits, will never be eliminated as long as the present laws remain on the statute books. The committee is informed that a plaintiff need only allege negligence or carelessness in order to obtain a court hearing, and that courts have frequently been prevented from granting a nonsuit by reason of such allegations.

The Council recommends a review of the statutes and decisions of other states in an effort to ascertain whether or not procedural legislation might not be suggested which would afford better protection to licensed persons.

Your committee further recommends that every member of the California Medical Association should be a member of the Medical Society of the State of California; although a member's liability insurance policy provides the member with the services of the carrier's attorney, that attorney, under the ethics and principles of his profession, must represent the insurance carrier first. Hence, the defense service of the member is directed to the fulfillment of his client's conception of its contract with him, and it is the company's interest which he must at all times protect.

The Medical Society of the State of California makes it possible for its members to secure the personalized supervision of and participation in all legal problems and trial conduct of their own personal attorney, thus assuring full protection of each member's personal and professional interest. The Society indemnifies the member for the expense of his attorney. The member's attorney, by means of coöperation with the insurance company's attorney, is able to provide the member with complete legal protection.

Respectfully submitted,

George G. Reinle, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

John H. Graves, Chairman, 1938
Edward M. Pallette, 1940 William R. Molony, Sr., 1939

To the President and the House of Delegates:

The committee has held no meetings during the past year.

Meetings of the Committee on Public Relations have been attended by some members of the Medical-Economics Committee, and correspondence has been exchanged among the members.

In view of the development of numerous activities in the field of medical economics, it appears likely that the coming year will present more problems that will come within the scope of the committee than demanded attention during the past twelve months.

Respectfully submitted,

John H. Graves, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

Loren R. Chandler, Chairman, 1939
John B. Doyle, 1940 B. O. Raulston, 1938

To the President and the House of Delegates:

Your Committee on Medical Education and Medical Institutions has considered matters referred to it by the Association concerning the activities at one of the State institutions, making recommendations to our Council.

This committee has coöperated with the Committee on Postgraduate Education and with the four medical schools in California in postgraduate medical education. Inasmuch as the activities of the medical schools in California are described adequately from time to time in bulletins and reports, your committee sees no need to present at this time another report on their activities.

Respectfully submitted,

L. R. Chandler, *Chairman.*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

E. Vincent Askey, Chairman, 1938
G. Dan Delprat, 1940 Dewey R. Powell, 1939
The Secretary, ex officio

To the President and the House of Delegates:

Your Committee on Membership and Organization has held no special meetings. The attention of your committee has been given to encouraging and noting the various efforts of your county societies in the constant procedure of recruiting members.

Since the recruiting of members must be in the hands of the county societies primarily, we would suggest that your body encourage each county society to make a survey such as was recently made by one large county unit. This survey showed the following statistics:

Total number of nonmembers in county	1,923
Number of former members who have been dropped for nonpayment of dues	313
Number of nonmembers who may be eligible but are over 55 years of age	598
Number of nonmembers who are eligible and are under 55 years of age	798
Number of nonmembers with evidence indicating that they are not eligible	137
Number of nonmembers who have applied but have been rejected	55
Number of nonmembers who are not listed in any directory	22

With this knowledge it is possible to put on an active campaign to induce those eligible and desirable to join without loss of effort and with the greatest efficiency.

We need not again emphasize the importance of the strongest alliance among all doctors of medicine. A membership as large as possible is the first step toward welding our profession into an efficient militant organization, defending scientific medicine and our professional rights.

Respectfully submitted,

E. Vincent Askey, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

John C. Ruddock, Chairman, 1940
F. E. Clough, 1938 F. F. Gundrum, 1939
The Secretary, ex officio

To the President and the House of Delegates:

The Committee on Postgraduate Activities has had several meetings during the past year as well as various correspondence concerning its activities.

The committee this year has carried on the work that had been started in previous years by former committees. The Council of the California Medical Association has recognized the obligation of the California Medical Association to afford apportunity to its members to engage in continuous educational studies with a minimum of inconvenience, time and expense. It has promptly carried out the recommendations of the committee in causing to be published, as a supplement to California and Western Medicine in the November, 1937 issue, a five-year study program for graduates in medicine. There has been listed in this supplement 103 subjects for postgraduate programs. The committee realizes that this supplement is incomplete, and at the present time is revising it as experience shows the need for changes and where subjects have had need to be added and supplemented. The committee feels that the precedent that has been established by the publication of a five-year study program for graduates in medicine is very worth while and answers one of the problems and justifies the existence of organized medicine. The subjects as listed in the supplement are not intended for didactic work in medicine. They are not intended to provide physicians for any specialty, but they are intended to afford an opportunity to the members of the California Medical Association to remain abreast of scientific progress and to apply it in their daily practice with an understanding of the underlying problems and fundamentals.

The committee realized that there are certain members of the California Medical Association who will not embrace the opportunities that are offered them. However, the opportunities will be available and if they are not taken advantage of, then those men will lose who do not embrace them. The committee intends to further report in detail concerning certain problems of its plans for work to the House of Delegates.

Respectfully submitted,

John C. Ruddock, *Chairman.*

COMMITTEE ON PUBLICATIONS

Executive Group

Ralph Eusden, Chairman, 1940
Ruggles A. Cushman, 1938 Oscar Reiss, 1939
The Editor, ex officio The Secretary, ex officio

To the President and the House of Delegates:

The detailed report of the editor may be considered part and parcel of this committee's report.

With the physical arrangement of the contents of the official journal, and its editorial policy and comment and projected plans, the committee is in full accord.

In these days of economic and political unrest, the medical profession is increasingly faced with problems peculiar to its functions, not only with its organization and stability, but to the public.

Therefore, editorial comment and publication of articles pertinent to the Association's place in the political and professional sun will be increasingly forthcoming, to the end that our membership may be well and honestly advised, and our rights and position maintained.

Our official journal has reached an outstanding position in the field of the state and regional medical journals, and its efforts to bind together the membership in a well-advised manner, as well as to give members scientific information of an up-to-date and useful nature, shall continue to be a major purpose.

Complaints have been scarce. Papers submitted are fairly considered, and the editorial policy of giving preference to annual session papers and clinical presentations has our continued approval.

This being an election year the committee urges that you read the official journal in order better to acquaint yourselves with legislative matters of importance to the medical profession.

The committee requests for California and Western Medicine, as the official journal of the Association, the whole-hearted support of the Council and House of Delegates in its present and projected character and policy.

Respectfully submitted,

Ralph Eusden, *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

Frederick C. Warnshuis, Chairman, ex officio
Lemuel P. Adams, 1940 F. M. Pottenger, 1939
J. Homer Woolsey, 1938 Howard F. West, ex officio
Nelson J. Howard, ex officio

To the President and the House of Delegates:

The scientific program for this sixty-seventh annual session represents the major activity of this committee.

Your committee renews its recommendations that the House of Delegates give careful consideration to the desirability and advisability of selecting places for the holding of annual sessions that provide adequate accommodations for section meetings and scientific exhibits.

Respectfully submitted,

F. C. Warnshuis, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Charles A. Dukes. The secretary-director is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is, ex officio, a member of the Council. The Committee on Public Relations includes the following:

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.
Daniel Crosby, Chairman, Committee on Hospitals, Dispensaries, and Clinics.
Morton R. Gibbons, Chairman, Committee on Industrial Practice.
E. Vincent Askey, Chairman, Committee on Membership and Organization.
John H. Graves, Chairman, Committee on Medical Economics.
Junius B. Harris, Chairman, Committee on Public Policy and Legislation.
Charles A. Dukes, Chairman, Cancer Commission.
John C. Ruddock, Chairman, Committee on Postgraduate Activities.
Howard Morrow, President of California Medical Association.
William W. Roblee, President-elect.
Frederick C. Warnshuis, Secretary-Treasurer.

To the President and the House of Delegates:

From month to month in the Department of Public Relations in the Association's official journal, the Committee on Public Relations has rendered progress reports on its activities. This report will, therefore, be limited to a few comments and recommendations.

I.

Our professional relations to the public in general, and particularly to governmental agencies concerned with public interest, is most unstable and far from satisfactory. Changes and new proposals related to medicine and medical care occur overnight. Proposals are devised, altered, abandoned, and new plans are projected. There is a palpable instability and unrest. This attitude renders it impossible to submit a clear statement as to what has occurred or to predict what the tomorrows may bring.

Your committee feels that an ultimate and acceptable solution of this problem is dependent upon two fundamental principles that merit concentrated action. They are:

(*a*) The necessity of creating and maintaining public good will and confidence for the individual doctor of medicine and the units of our medical federacy.

(*b*) To cause the public and its governing agencies to recognize that our profession and its organizational units, by reason of their training, past achievements, experience, intimate contacts, and capability, are more competent to devise ways and means to satisfactorily meet the medical needs of all classes of people than any other agency, govern-

mental branches, or self-constituted groups or individuals who are outside the pale of medicine.

Your committee has sought to develop these two principles through several ways and by acquired contacts. Your committee alone is quite impotent to attain this public confidence. Attainment can only be accomplished through the persistent energetic efforts of every member who is called upon in his daily activities to embrace every opportunity to create public good will and confidence in the profession and its organizational representatives and spokesmen.

Your committee stresses the need of this solidarity and coöperation and urges that county societies concern themselves with these questions. Individualism, independent minority groups, and their quests, delay and confuse, thereby retarding early ultimate satisfactory establishment of acceptable relationship between the public and the profession.

II.

Coöperation with Public Agencies.—Maintenance of contacts and coöperation with lay and governmental agencies have been continued during the year.

The director has been elected to an office in the American Legion. He was also elected as a director of the California Safety Council and is serving on two important committees of that organization. Through the California Forestry Medical Service Corps he has maintained official contact and service with the Federal and State Forestry Services, and the State Highway Traffic Department.

Contacts have been maintained and coöperation continued with the following agencies: Department of Education; Board of Medical Examiners; Department of Health; Attorney-General; Insurance Commissioner; Compensation Board; Hospital Association; Nurses' Association; Federation of Women's Clubs; Business Women's Clubs; Young Women's Christian Association; WPA; and public Libraries.

In all of these contacts, a persistent, sustained effort is made to impart dependable information, foster good will, subscribe assistance, and develop mutual interests. Our files contain many expressions that warrant the time and work contributed to these contacts.

III.

Public Education.—The committee is appreciative of the assistance rendered by the Committee on Health and Public Instruction and some eighteen members for their time contributed in giving lectures to Y. W. C. A. and high schools and certain women's clubs. Although uninformed as to the details, the committee notes with commendation the public education program of the Los Angeles County Medical Association and its Speakers' Bureau.

The committee endorses and urges that county societies conform to the recommendations of the Committee on Health and Public Instruction.

An informed public, possessed of dependable information, will be of tremendous value in establishing sound policies.

IV.

Insurance and Hospital Service Plans.—Following investigations, conferences, and reviews, this committee has recommended that the Council endorse the following organizations issuing hospital insurance policies: Insurance Association of Approved Hospitals, Oakland, and San Francisco; Association of Southern California Hospitals; and the Intercoast Hospitalization Insurance Association. The committee will review and prepare recommendations for any other contemplated hospital insurance plans.

Health Service Plans.—The committee is advised, but is without factual details, that the American Medical Association Bureau of Economics is drafting certain recommendations for guidance when the formation of Medical Health Service is contemplated. Until these recommendations are available, it is recommended and urged that formation or affiliation with any and all health service groups or organizations be held in abeyance.

V.

Miscellaneous.—The year's activities include the following services:

(*a*) Information Bureau. Many hundreds of inquiries from the public and the profession are answered.

(*b*) Press releases to local newspapers.

(*c*) Distribution of approved literature to lay organizations and individuals.

(*d*) Maintenance of a reference library.

(*e*) Pacific Tri-State Conference.

(*f*) Golden Gate International Exposition.

IN CONCLUSION

The committee, composed as it is of chairmen of standing committees and officers, has served as an interlocking administrative unit for these Association committees. In this dual capacity it has, we believe, coördinated functions and accomplished worth while results that are beneficial to every member. In consequence, we are of the opinion that specific guiding recommendations should emanate from individual committees, and when approved by the House of Delegates, or the Council, such recommendations will be observed by this committee.

Respectfully submitted,

C. A. Dukes, *Chairman.*

V

REPORTS OF SPECIAL AND COUNCIL COMMITTEES

COMMITTEE ON ANIMAL EXPERIMENTATION

Executive Group

Philip K. Gilman, Chairman

Loren R. Chandler Charles A. Dukes

To the President and the House of Delegates:

Your Committee on Animal Experimentation met and the chairman was authorized to act as the committee's representative on the Executive Committee of the California Society for the Promotion of Medical Research.

It is possible some of you may not be familiar with the history, organization, and objects of this society. The following will make clear these points and emphasize the extreme importance of the organization.

In militant opposition to the so-called "State Humane Pound Law," which will come before the voters by Initiative petition at the General Election next November, the medical fraternity of California and their lay friends are enlisting under the banner of the California Society for the Promotion of Medical Research. This society will conduct the campaign against the latest attempt of the antivivisectionists to throttle scientific research into the causes and cures of disease in California.

For the first time since their defeat in 1922, the self-styled "humane" groups have come before the people with another of their time-worn attacks upon medical research. With plenty of funds apparently at their disposal, proponents of the "State Humane Pound Law" are busily disclaiming that this is an antivivisection measure. Yet high legal authority has declared the proposed law to be, in effect, antivivisection only thinly disguised, since it would cut off the source of supply of animals for experimental purposes.

The California Society for the Promotion of Medical Research was organized in 1915 by medical, educational, and business leaders throughout the State. It led the successful campaigns of 1920, 1922, and previous years against the antivivisectionists, and is today being strengthened for the campaign this fall by increasing its membership among all classes of our citizens.

Dr. Ray Lyman Wilbur, President of Stanford University, is president of the Society. The vice-president is Mr. Frederick J. Koster, Chairman of the San Francisco Chapter of the American Red Cross and former president of the California State Chamber of Commerce. The secretary is Dr. Salvatore P. Lucia of the University of California Medical School, and the treasurer is Mr. J. K. Moffitt.

The Finance Committee for Northern California comprises: President Ray Lyman Wilbur; Dr. Robert Gordon Sproul, President of the University of California; Right Reverend Charles A. Ramm, Rabbi Irving F. Reichert, and William Kirk Guthrie, D.D.

The Campaign Committee for Northern California is headed by Philip K. Gilman, M.D., as chairman. The other

members are: Eldridge J. Best, M.D., Delegate to the American Medical Association; Ernest Sloman, D. D. S., Superintendent of the College of Physicians and Surgeons; Mr. James Leo Halley, President of the West Coast Laboratories, Ltd., and Joe G. Sweet, attorney at law.

The committee for Southern California has for its chairman, Dr. Robert A. Millikan, President of the California Institute of Technology. Serving with Dr. Millikan on the Finance Committee are: Dr. Rufus B. von KleinSmid, President of the University of Southern California; Remsen du Bois Bird, President of Occidental College; Charles K. Edmunds, President of Pomona College; Rabbi Edgar F. Magnin, Robert Freeman, D.D., and Louis B. Mayer.

The California Campaign Committee is under the chairmanship of Dr. B. O. Raulston, member of the Committee on Medical Education and Medical Institutions of the California Medical Association. Included among those serving with Doctor Raulston on the committee are: Donald J. Frick, M.D., Percy T. Magan, M.D., John R. McCoy, D.D.S., Bennett Allen, Professor of Zoölogy of the University of California at Los Angeles; John W. Henderson, General Manager of the California Supply Company; and Robert Jennings, attorney at law.

The campaign against the enactment of the vicious "Humane Pound" legislation will see a preponderance of lay men and women lined up in active opposition to this antivivisection measure. In the opinion of the Society this is everyone's fight—not simply a defense of medical progress by medicine itself. Every effort is being made to attract to the membership rolls as many nonprofessional citizens as possible. Yet stress is being laid upon the fact that physicians and surgeons, dentists, veterinarians, registered nurses, and professional educator throughout California must be alert and actively coöperative if the campaign to defeat the Initiative is to be successful.

Endorsements of the California Society for the Promotion of Medical Research, and of its campaign against the "State Humane Pound Law," are being received daily from scientific and educational organizations in all sections of the country. Among others are the American Medical Association, California Medical Association, Public Health League of California, American Association for the Advancement of Science (250,000 members in affiliated groups), Society of American Bacteriologists, American Genetic Association, Western Society of Naturalists, and Northern California Retail Druggists' Association.

Of more than ordinary importance is this year's campaign of the Society to protect medical research against the onslaughts of sentimentalists. California, with its great university research laboratories, leaders in scientific discoveries tending to ameliorate the ravages of disease, is being made the testing ground for the nation by the antivivisectionists, as they, themselves, admit.

And—to quote *Hygeia*, monthly publication of the American Medical Association,

Let the antivivisectionists win but one victory in their campaign, which has persisted since 1875, and no one can tell where their insidious drive will end!

President Wilbur has urged that all who have received communications from the Society join at once so that the effectiveness of its work may not be delayed.

Headquarters are at 369 Pine Street, Suite 325, San Francisco (Sutter 8118), and 352 Chamber of Commerce Building, Los Angeles (Prospect 1338).

Your committee, therefore, recommends and moves that the House of Delegates authorize and instruct each county society composing the California Medical Association to appoint a special committee whose duty it shall be to enlist the support and arouse the interest of all voters in their community and by proper education cause them to aid in defeating this Initiative. Such committees as organized shall communicate with the secretary of the California Medical Association and the chairman of your Committee on Animal Experimentation for mutual assistance and coördination of activities.*

Respectfully submitted,

P. K. Gilman, *Chairman.*

* EDITOR'S NOTE.—For a recent discussion of the value of animal experimentation, see CALIFORNIA AND WESTERN MEDICINE, April, 1938, on pages 257 and 258.

CANCER COMMISSION

Executive Group

Charles A. Dukes, Chairman
Otto Pflueger, Secretary
Orville Meland, Secretary for Southern Section

A. Herman Zeiler — Harold Brunn
Gertrude Moore — Henry J. Ullmann
Clarence G. Toland

To the President and the House of Delegates:

The Cancer Commission has felt that its first obligation is to the practicing physicians in this State, its duty being to increase the knowledge of cancer in order that patients may receive the best care at the earliest opportunity. The activities during the past year have centered about this obligation.

The annual study meetings for pathologists and roentgenologists were held at the last State meeting in Del Monte and were well attended. Likewise, a midwinter meeting for pathology was held in San Francisco, with forty-five physicians attending, representing all sections of the State. It is gratifying to see the increasing number of general surgeons who attend these meetings, and it has constantly been necessary to have greater space for them. Plans are under way for the meetings to be held in Pasadena in May. We feel these meetings are one of the highlights of our annual State session. The Cancer Commission desires an active part in the postgraduate study program, and feels that cancer should be accorded a special section in this program.

Feeling that it would be worth while to acquaint the medical profession at large concerning the Cancer Commission and its activities, a scientific exhibit at the annual meeting of the American Medical Association in San Francisco is being planned under the direction of Doctor Ullmann.

The Commission is justly proud of its activity in the preparation of the reports on cancer which have been published, and we note with pleasure that this procedure, initiated by the Cancer Commission, is being followed by other organizations, such as the Canadian Medical Association. The compliments of national authorities on our effort have been of the highest. Knowing that the field of cancer is anything but static, we would recommend that these reports be revised and brought up to date at an early day. Your committee has other plans for the future, though perhaps still somewhat visionary. These pertain to a general acceptance of a centralization of activities with regard to the diagnosis and treatment of cancer. We should like to be instrumental in the formation of diagnostic and/or treatment clinics according to plans already worked out by the Commission, to be used in all hospitals throughout the State. Where smaller hospitals have not the facilities, patients could be referred for diagnosis to the group in a near-by larger hospital. We feel that such groups would derive great benefit themselves, be instrumental in spreading knowledge to other physicians, and would make available to patients the best possible service.

Organization of Cancer Committees and Clinics

The following paragraphs outline suggestions for the organization of cancer committees and clinics:

At the present time it appears feasible in California to organize two types of cancer groups:

1. A purely diagnostic group in small hospitals and communities where adequate radium and other equipment for the handling of all types of malignancies cannot be economically maintained. Patients should be referred for treatment to larger centers, where adequate equipment is available.

2. A diagnostic and/or treatment group in hospitals and communities where adequate apparatus and equipment already exist or can be obtained and economically operated.

The principles of organization and conduct of both groups are substantially the same, except for the requirements of equipment.

PRINCIPLES

1. *Purpose.*—The group should bring together knowledge, training, and skill from all the various fields of medicine bearing upon the diagnosis of cancer and its treatment, recognizing that the proper diagnosis and handling of cancer at the present time requires special knowledge, train-

ing, and experience in more fields than any one physician can ordinarily expect to acquire.

2. *Personnel.*—The minimum personnel must include a surgeon, pathologist, a radiologist, and an internist, all specially trained and experienced in cancer. If they are available, it is desirable to include specialists in still narrower fields, *e. g.,* gynecology, eye, ear, nose and throat, genito-urinary organs, neurosurgery, chest surgery, etc. An internist or a young practicing physician who is not too busy to take histories and look after them would be advantageous in the group.

3. *Meetings.*—Regular stated meetings of the entire group should be held for the discussion of all cases referred to it, the frequency of meetings depending upon the volume of cases to be considered (usually not less often than once a week). *Diagnoses and recommendations for treatment should come from the group and not from individuals.* It should be understood that patients once seen for diagnosis will return to the group for regular follow-up examinations.

4. *Records.*—Accurate records of patients and of the discussions of the group about them must be made and kept. The keeping of such records must be the responsibility of some individual and this will doubtless require, for satisfactory operation of any group, a paid full-time or part-time secretary. Sufficient forms for records may be obtained from the American College of Surgeons' Cancer Committee.

5. *Radiotherapeutic Equipment.*—1. X-ray equipment—adequate for all diagnostic purposes, and apparatus for high voltage x-ray therapy. 2. Radium—a minimum of 100 millimeters, preferably as a salt, with the necessary applicators and filters.

If treatment is to be undertaken under the direction of the group, minimum equipment, such as laid down in the report of the Radiology Committee of the Cancer Commission in December, 1932, should be available. Needless to say, the surgery and radiotherapeutic departments should be under the direction of experienced workers. The indiscriminate use of x-ray and radium in the hands of anyone but experts will do more harm than good.

6. *Present Functions of Cancer Clinics.*—The Cancer Commission believes that there are at present desirable cancer committees as follows:

(*a*) Cancer committees in general charity hospitals (county hospitals, etc.). Whether or not the Cancer Committee should operate a separate service, assuming complete charge of diagnosis and treatment of the cancer patients in the hospital, will depend on the wishes of the staff. In general, probably the best plan at present is for the clinic to see all cancer patients in the hospital, advising line of treatment to be undertaken and referring patients back to the services from which they came for carrying out of the treatment. Such patients should be seen from time to time by the committee for check of results of treatment and follow-up.

(*b*) Cancer committees organized to serve a private hospital or the community in general.

The Cancer Commission believes that at the present time such cancer committees should offer a consultation service for physicians, should make no charge for consideration of patients, should accept no patients for examination and diagnosis who are not referred by physicians, and should refer patients back for treatment. If, then, the physician originally referring a patient desires to have treatment carried out by a member of the Cancer Committee, arrangements for this should be on the usual private patient consultation basis.

7. *County Medical Society Support.*—Organization of cancer clinics or groups should be carried out by, and with the coöperation of local county medical societies.

Reference is made to the recommendations of the American College of Surgeons' Committee on the Treatment of Malignant Disases—"Organization of Service for the Diagnosis and Treatment of Cancer: Minimum Standard." This report may be obtained in pamphlet form, published in June, 1931, from the American College of Surgeons, Chicago. Reference is also made to the *Bulletin of the American College of Surgeons* for December, 1931.

Respectfully submitted,

Charles A. Dukes, *Chairman.*

COMMITTEE ON REPORT OF FACTUAL DATA OF CALIFORNIA MEDICAL-ECONOMIC SURVEY

Executive Group

Edward M. Pallette

Howard Morrow George H. Kress

To the President and the House of Delegates:

The special committee appointed last year, and to whose members was delegated the task of bringing off the press the "Report on Factual Data" of the California Medical-Economic Survey, completed its task when, in November, 1937, it placed in the mails, for each member of the Association, a copy of the 221-page report, and transferred one thousand additional copies to the Association office for distribution and sale under Council direction.

Concerning views that may be held regarding the Report as printed, in relation to factual inadequacies, costs, and other phases, it may be in order to state that it was no easy task to try to analyze and make presentable the voluminous copy submitted by the Survey Director, who had been employed to supervise the collection and compilation of the statistical data used in the creation of the tables, charts, and graphs. The burden of this onerous work fell almost entirely upon the shoulders of one member of the committee, the Editor, who generously gave not only hours, but days, to this labor, so important for the California Medical Association, in order to bring it to a conclusion that would be satisfactory both to the Federal authorities (WPA) and to the Association.

Every table, graph, and chart that was included in the Survey Director's report was printed, the committee adding thereto some explanatory addenda and interpretations which it deemed necessary to a proper understanding of the factual data. To what extent the Report may continue to be a subject of discussion by certain interests we do not know, and that need concern us but little, because the Federal authorities at Washington have stated that, in their opinion, the project has been completed; and the California Medical Association having more than done its part, certainly has an equal right to feel the matter is closed, so far as it is concerned.

Your special committee desires to add its personal comment that it hopes that members of future Houses of Delegates will carefully consider enterprises of this nature before embarking the Association on a series of expenditures which, in the present case, resulted in an outlay of the massive sum of $50,000 dollars of its reserve funds.

Respectfully submitted,

Edward M. Pallette, *Chairman.*

SPECIAL COMMITTEE ON A QUALIFYING CERTIFICATE (BASIC SCIENCE) LAW

Executive Group

George H. Kress, General Chairman
Morton R. Gibbons, Chairman (for Bay Region)
Edward M. Pallette, Chairman (for Southern California)
Junius B. Harris, Chairman (for remainder of State)

To the President and the House of Delegates:

As the report of the Special Committee on a Basic Science Law for California, we are submitting the somewhat detailed review of the subject, made to the Council of the California Medical Association at its meeting held on January 15, 1938.

The Council at the meeting referred to, accepted the report and instructed the Special Committee to continue its studies and make future recommendations. (See Minutes, item 24, on page 126, in California and Western Medicine, February, 1938.) The Council, because of the many initiatives to be placed before the electorate this year, also voted that no effort should be made to submit a Basic Science initiative act on the ballot of the November, 1938, state election. There is almost a unanimity of thought on the need of a Basic Science law as a proved means that will both protect the citizenry from incompetent healing art practitioners and at the same time maintain, at least in part, healing-art educational standards. On the other hand, since California has multiple healing-art boards (two of the three, through initiative laws) a Basic Science act, to apply to the three existing boards, and possible future boards, almost necessarily must be brought into existence

through a law that would be enacted by initiative vote of the electorate.

Appended hereto is the committee's report, as submitted to the Council on January 15, 1938. The perusal thereof is commended to all members who wish to orient themselves on the subject.

Respectfully submitted,

George H. Kress, *General Chairman.*

* * *

COPY OF REPORT SUBMITTED TO THE COUNCIL

Los Angeles, January 15, 1938.

To the Council of the California Medical Association:

Your Special Committee on Basic Science Law for California submits herewith a progress report:

At the 1937 annual session at Del Monte, the Reference Committee on reports of standing and special committees reported as follows:

Report of the Special Committee on Qualifying Certificate Law.—Although your committee is in favor of the passage of the Qualifying Certificate (Basic Science) Law, it does not feel that the expenditure of the moneys necessary therefor is feasible at this time, and recommends that this matter be held over for another year.

The committee recommends adoption.

After an explanation [to the House of Delegates] of the necessity of a qualifying certificate law in this State, by Dr. George H. Kress of Los Angeles and Dr. Lowell S. Goin of Los Angeles, a vote was taken and the motion did *not* carry.

At the Council meeting held on October 3, 1937, following the October 2 joint meeting of State Association and county officers and committees, at which a Basic Science law was approved, with no opposing votes cast, the Council voted (item 8, page 337, November, 1937, California and Western Medicine):

. . . that the Committee on Qualifying Certificate Law be instructed to proceed with the preparation of an initiative, in as nearly the final form as possible, and to submit it to the Council. Carried.

The Executive Committee of the California Medical Association, at its December meeting in 1937, upon motion of President-Elect Roblee gave the Special Committee on Basic Science specific instructions to submit to the Council at its January 15, 1938, meeting in Los Angeles, as complete a draft of a final Basic Science law as could be put into form.

Acting under these instructions the general chairman of the special committee proceeded to make, as rapidly as was possible, some formative drafts (copies being sent to the subchairmen, Doctors Gibbons, Harris and Pallette, General Counsel Peart, President Morrow, and President-Elect Roblee, for their information and suggestions.)

* * *

This progress report herewith submitted to the Council is made by the general chairman of the committee, and in it he presents his own and, in good part, the views of Subchairman Pallette, which give the conclusions reached by them since their first Basic Science committee meeting of the Los Angeles County Medical Association, which was held in the year 1927.

Early in their studies, as then taken up, and in order to get the reaction of the profession and the public, they submitted to the California Legislature of the year 1929, Assembly Bill No. 666, a printed copy of which is attached to this report as *Exhibit "A."*

In the years that followed, through the newly instituted Council Special Committee on Basic Science Law, consisting of Dr. George H. Kress as general chairman, Dr. Morton Gibbons as subchairman for the Bay region area, Dr. Edward M. Pallette as subchairman for Southern California, and Dr. Junius B. Harris as subchairman of the remainder of the State, the medical profession of California was reminded that in a State such as our own, with multiple examining boards, and with not only an appallingly large number of cultist and would-be cultist healing-art practitioners (as well as succeeding legislatures, whose members seemed increasingly susceptible to the lures put out by cultist groups seeking legal recognition), it was a grave question whether the medical profession of California should not actively make an effort to protect the standards of scentific medicine and the public health by sponsoring and striving to push to enactment a Basic Science law modeled after those which in other states of the Union had produced much to be desired results.

Accordingly, a number of tentative drafts of Basic Science laws, under the name "Qualifying Certificate Acts," were drafted and studied by the Special Committee and from time to time were referred to editorially and otherwise in the official journal of the Association.

In our last legislature, (1937), in order again to test out the reaction of healing-art groups and the public of California, a draft, known as Assembly Bill No. 1552, was introduced. A printed copy thereof is attached to this report as *Exhibit "B."*

A printed copy of the Iowa Basic Science Law (a state possessing, like California, multiple examining boards), which was enacted in 1936, is attached hereto and marked *Exhibit "C."*

Copies of a mimeographed modification of this recent Iowa law, drafted to permit adaptation to the needs of California, have been sent to each councilor, and a copy, marked *Exhibit "D,"* is attached hereto.

Likewise, a copy of the printed Basic Science law model, drafted by the Medico-Legal Bureau of the American Medical Association, marked *Exhibit "E,"* is submitted.

The undersigned general chairman also submits some American Medical Association analyses of all existing Basic Science laws; and copies of the full text of the same, should occasion arise for their consideration. These are attached as *Exhibit "H."*

The above reports and addenda on this important subject are presented for possible consideration in the decision which the Council should make today—on whether a draft of a Basic Science law should be placed on the State election ballot of November, 1938.

Before a Basic Science law is placed on a state election ballot it will be necessary for the Council to make decisions on the items which follow:

1. *Initiative Law.*—This Council agrees, we believe, that any Basic Science law, to be of real or permanent value to California, should be an initiative act enacted into law by vote of the electorate, and not a legislative enactment.

2. *Costs of Signatures of Voters to Initiative Petitions, etc.*—It should be realized that in order to secure the 185,395 valid signatures of voters, with correct precinct allocations, all in conformity with the State election laws, it will be necessary for our Association to spend between $25,000 and $30,000 as follows:

(*a*) The sum of approximately $20,000 for the necessary signatures. A bid from a well-known California signature firm, marked *Exhibit "F,"* is attached to this report, the bid from this company being $19,350. The matter of securing signatures by doctors through their secretaries, and the amount of moneys to be saved thereby, etc., is not here discussed. It can come up in oral discussion.

(*b*) The sum of $6,000 for purchase of 570,000 postcards . . . (use explained verbally to Council), one hundred of such, with a brief request for support of the Basic Science bill printed thereon, to be sent to every member of the California Medical Association. Each member to be requested to send these one hundred postcards to one hundred of his patients or friends (who, naturally, as patients, are logical supporters of scientific medicine and a Basic Science law).

These 600,000 postcards should provide contacts with twice or thrice that number of voters, and on a proposed law, so evidently needed on its face, this should mean that these one to two million or more voters contacts would put this Basic Science law across to successful enactment by one of the largest majorities yet recorded for a successful initiative measure. Copy for such a postcard, marked *Exhibit "G,"* reading somewhat as follows, is attached:

(Suggested Postcard Request)

(Salutation)

Dear Friend:

On your election ballot you will find Initiative No..... (Basic Science Law). Its purpose would make it necessary for all doctors to have at least a high school education.

Certainly, that is not too much to ask of those in whose hands you and yours place your health and lives.

If you could vote "yes" for this law, and also speak in its favor to your friends, I would greatly appreciate your action.

* * *

Other measures on this year's ballot, on which I shall vote "no," because I think they are against the public health interests of California, include:

(Title) Initiative No.....

(Title) Initiative No.....

Cordially yours,

.....

M.D.

(*c*) Incidental expenses should not exceed $1,000 to cover postage, printed matter, etc., provided we refrain from foolishly expending funds by cheap, controversial argument over the radio networks.

3. *Shall a Basic Science Law Be Submitted in the State Election in the Current Year, 1938, or Shall It Be Postponed for the State Election of Two Years Hence, in 1940?* This thought is referred to at this point simply to remind the councilors thereon before taking up the question of whether the Initiative is to be submitted in 1938 or 1940; a decision which necessarily must depend upon whether we can draft an Initiative Basic Science law, such as we would be willing to place on this year's State election ballot. This subject is further considered in Item 4, which follows.

4. *What Would Be a Satisfactory Draft of an Initiative Basic Science Law?* Facts of fundamental importance in an "Initiative law," to be presented to the California electorate, imply that the proposed law shall be written in soundest legal form, preferably in language which has been found acceptable to the higher courts in previous decisions; that it shall not be overlengthy; that its provisions, while being specific for the ends desired, shall not be of a nature to become frozen sections with the passing years, because amendments to an initiative law may prove just as expensive of enactment as was the original act; and that the proposed law itself shall have sufficient merit in attainable end-results to warrant the expenditure of a sum necessarily approaching so large an amount of the Association's funds as almost $30,000.

For the above reasons the mimeographed Qualifying Certificate law, which was submitted to the last legislature as a form of gesture, was deemed unsatisfactory as a working model, and the Iowa Act of 1936, in which the experience with prior Basic Science laws was utilized, was taken as a good type to modify.

Such a form was drafted, sent to each councilor as *Form "B"* with request for perusal and study, and a copy, with a long list of queries on legal points, was sent by the Special Committee chairman to General Counsel Peart, with request that Mr. Peart analyze the draft and make report thereon at this January 15 meeting of the Council.

Concerning the modification or draft submitted today (*Form "B"*), attention is called to the following points:

The committee has gone back, therein, to the use of the term "Basic Science Law" because every other similar law in the United States is so named, and legal decisions are recorded under that title.

Concerning the number and sciences in which examinations would be given, the committee decided on five absolute subjects, instead of a choice of five out of ten, lest legal complications should arise in giving such a choice (since every candidate would not have taken his examination on exactly the same subjects).

The five subjects chosen are those which are in practically every Basic Science law. Certainly no objection can be made to the three subjects of anatomy, physiology, and chemistry, as Basic Sciences. Bacteriology and hygiene seem to be the two other subjects that might be acceptable to all groups of healing-art practitioners. (Whether these should be designated nonmedical bacteriology or elementary bacteriology, or nonmedical hygiene, or whether subjects like embryology, botany, zoölogy, biology, or even English would be preferable to bacteriology and hygiene, for one, or both, is a debatable question, which the Council may wish to consider.)

The examining board would consist of five members, namely, of faculty members not holding healing-art degrees, attached, one each, to the faculties of the University of California, Stanford University, University of Santa Clara, University of Southern California, and the California Institute of Technology.

A clause was inserted in the draft which provided that the heads of these five universities would suggest to the Governor the names of three to five faculty members, not as nominees for the Basic Board of Examiners, but simply for possible consideration by the Governor. Whether this is desirable in an initiative law, is a question. It may be better to make it mandatory for the Governor to appoint a faculty member from each of the five universities; with a provision, however, that if any one of these institutions passed out of existence in the days to come, he could select some other university or four-year college located in California which had accredited collegiate standing with the State University of California, from which to select a faculty member for the Basic Science Board.

The proposed law would not be made to apply to any healing-art practitioners licensed in California at the time of its enactment, nor to healing-art students who had matriculated prior, say to January 1, 1939, nor to certain other professional and semiprofessional groups. Nor to Christian Scientists, whose publication committee has submitted for inclusion the exemption phraseology of the United States Service exemption clause.

To prevent an Initiative Basic Science law from becoming "frozen" in the years to come, it might be desirable to insert a clause permitting the passing of certain types of amendments, through legislative enactment of appropriate acts, submitted as amendments to the Medical Practice Act of California, or the Professional and Vocational Standards Act, or some pertinent public health act.

Each of the other sections of the proposed law could be commented upon, but since General Counsel Peart may present these to the Council, further discussion in this report may be waived.

In conclusion, it is proper to state that the general chairman of the Special Committee on a Basic Science Law makes this progress report in compliance with the implied instructions of the House of Delegates, and the direct instructions from the Council and Executive Committee to so do.

In common with many other members of the California Medical Association, he believes that a Basic Science law could render a beneficent service to public health and medical standards of our State. The provisions and language of the law, and the form in which such an Act would be submitted to the California electorate, is a decision that must be made by the constituted authorities of the Association, namely, its House of Delegates and Council.*

Respectfully submitted,

George H. Kress, *General Chairman.*

* A list of reports on qualifying certificate laws, printed in CALIFORNIA AND WESTERN MEDICINE, includes the following:

Vol. 32, No. 4, April, 1930, page 288. One hundred and eighty-sixth meeting of the Council of the California Medical Association. Item 30, Medical Practice Act and Basic Science Act.

Vol. 32, No. 6, June, 1930, page 430. Report of Special Committee on Revision of Medical Practice Act and of a possible Basic Science Act.

Vol. 34, No. 6, June, 1931, page 448. Report of Special Committee on California Medical Practice Act and on a proposed qualifying certificate (so-called basic science) law.

Vol. 35, No. 3, September, 1931, page 228. Editorial.

Vol. 35, No. 3, September, 1931, page 239. Miscellany.

Vol. 36, No. 2, February, 1932, page 128. Report of Special Committee on Medical Practice Act and on Qualifying Certificate Law.

Vol. 36, No. 6, June, 1932, page 439. Report of Special Committee on California Medical Practice Act and on a qualifying certificate (so-called basic science) law.

Vol. 41, No. 5, November, 1934, page 339.

Vol. 42, No. 1, January, 1935, pages 39 and 53.

Vol. 43, No. 4, October, 1935, page 304.

Vol. 43, No. 5, November, 1935, page 321. Editorial.

Vol. 43, No. 6, December, 1935, page 395. Editorial.

Vol. 44, No. 1, January, 1936, page 2. Editorial.

Vol. 44, No. 4, April, 1936, page 252. Editorial.

Vol. 44, No. 4, April, 1936, page 349. Special article.

Vol. 45, No. 3, September, 1936, page 218. Editorial.

Vol. 46, No. 1, January, 1937, page 4. Editorial.

Vol. 46, No. 4, April, 1937, page 53. Report.

COMMITTEE ON SYPHILIS

Executive Group

Howard Morrow, Chairman
Charles W. Barnett William H. Goeckerman

To the President and the House of Delegates:

The Venereal Disease Act was passed by the legislature in May, 1937, was signed by the Governor, and became a law on August 27, 1937. Under the provisions of the law, the Bureau of Venereal Diseases was created as a separate bureau within the California State Department of Public Health. The State program is administered by the State Department of Health, under the direction of Dr. Walter M. Dickie, Director of the Department. The Bureau was reëstablished in February, 1937, and Dr. Malcolm H. Merrill was appointed as chief of the Bureau.

The system for reporting cases of venereal diseases has been simplified and modernized. The number of cases reported has increased by 50 per cent since these cards went into use, which shows a better coöperation of the physicians in reporting. Surveys have indicated that less than 10 per cent of the cases treated by private physicians have been reported. When the Bureau was established, thirty-five venereal clinics were reporting at monthly intervals to the State Department. The number has increased to seventy-seven. Another step has been to improve the general standard of medical care within the clinics. Almost all clinics have adopted the policies concerning admission laid down by the Bureau of Venereal Diseases, namely:

(*a*) Any patient for initial diagnosis and emergency treatment.

(*b*) Any case referred by a private physician for tests and consultation.

(*c*) Any patient unable to pay a private physician for treatment. Residency requirements have been abolished.

The Sacramento City Health Department Clinic was selected to determine the workability of various procedures of record keeping, treatment schedules, nursing procedures, etc. The same general plan is being inaugurated in the Fresno Hounty Hospital Clinic, and will be extended as rapidly as possible to all clinics of the State that will coöperate with the State Department. The State Department of Public Health is assisting these clinics by providing equipment, clinic record forms, drugs, and personnel. A series of seven pamphlets have been issued. Two hundred thousand have been sent out from the State Department. Over one-half of these have been mailed directly to individuals as a result of requests.

The United States Public Health Service film, "Syphilis," has been shown to over fifty audiences. A series of seminars is being planned for county medical societies, to be carried on during the months of May and June. The services of Dr. Udo J. Wile, Professor of Dermatology and Syphilology of the University of Michigan Medical School, have been obtained for this purpose. This Committee on Venereal Diseases from the California Medical Association is coöperating in every way with the United States Public Health Service and the California State Department of Public Health.

Respectfully submitted,

Howard Morrow, *Chairman.*

The New York Academy of Medicine

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